

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8055

FILED MAR 24 1947

State File No.

Registration District No. 42

Primary Registration District No. 5134

Registrar's No. 394

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Industrial City, Washington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Industrial City
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

In this community..... 10 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) County Missouri (b) County Buchanan

(c) City or town Industrial City
(If outside city or town limits, write "RURAL")

(d) Street No. Industrial City
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Samuel Thomas Divinia

3. (b) If veteran, name war..... No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced..... Married

6. (b) Name of husband or wife Sarah Tabitha Divinia

6. (c) Age of husband or wife if alive..... 76 years

7. Birth date of deceased September 7 1871
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
✓	<u>75</u>	<u>6</u>	<u>9</u>	hr. min.

9. Birthplace Caldwell County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Owner

11. Industry or business Orchard Business

12. Name Samuel Divinia

13. Birthplace Caldwell County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Jane Kates

15. Birthplace Caldwell County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Sarah Divinia

(b) Address Industrial City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Walter Bowman

(b) Address St. Joseph, Mo.

19. (a) 3-20-47 (Date received local registrar) (b) E. L. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16
year 1947 hour 2 minute P.M.

21. I hereby certify that I attended the deceased from Mar 4, 1947 to Mar 16, 1947
that I last saw him alive on Mar 15, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia 5 or 6 days
Duration

Due to

Due to C

Other conditions Paralytic agitaw 4 hrs
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 107

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

23. Signature Dr. D. J. ... (M. D. or other) MD

Address St. Joseph Mo Date signed 3-17-47

PHYSICIAN
Underline the cause to which death should be charged statistically.

1/21/11

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or ~~my~~.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Eugene Wood*
Licensed Embalmer No. *3804*
P. O. Address *319 So 10th St, Joseph, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.