

S. No. 2
M-5-43
v. 5-17-39
I X36871

FILED OCT 2 1948

Registration District No. **310**

Primary Registration District No. **3058**

1. PLACE OF DEATH:
 (a) County **St Charles**
 (b) City or town **St Charles**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1073 Madison St 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **70 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **St Charles**
 (c) City or town **St Charles**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1073 Madison St**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Joseph Hazel White**
 3. (b) If veteran, name war **No** 3. (c) Social Security No. **498-07-9467**

4. Sex **Male** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Sadie White** 6. (c) Age of husband or wife if alive **60** years
 7. Birth date of deceased **June 28 1869**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	78	2	12	hr. min.

9. Birthplace **St Charles** **Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Attendant**

11. Industry or business **Hospital**

MOTHER FATHER
 12. Name **Thomas White**
 13. Birthplace **Virginia**
(City, town, or county) (State or foreign country)
 14. Maiden name **Elizabeth Leak**
 15. Birthplace **England**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Sadie White**

(b) Address **1073 Madison St**

17. (a) **Burial** (b) Date thereof **Sept. 14 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove Cemetery**

18. (a) Signature of funeral director **Harold W. Baur, Inc**

(b) Address **St Charles Mo**

19. (a) **Sept 23, 1948** (b) **Frankie Hamilton**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **10** year **1948** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **July 2 1948** to **Sept. 10 1948** that I last saw him alive on **Sept 9 1948** and that death occurred on the date and hour stated above.

Name and cause of death: **Sanguine Heart Failure 6 days**
Mitral Regurgitation?
 Due to _____
 Due to _____

Other conditions: **Arterio Sclerosis**
(Include pregnancy within 3 months of death)

Major findings: **A B**
 Of operations _____
 Of autopsy _____

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? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place)
 (e) Means of injury _____

23. Signature **Frankie Hamilton** (M. D. or other) _____
 Address **St Charles Mo** Date signed **9-15-48**

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

