

No. 300
10-48

FILED AUG 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26133

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 922

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| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> | |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Joseph, Mo.</u>) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph, Mo.</u> | |
| c. LENGTH OF STAY (In this place) <u>8 Mos.</u> | | d. STREET ADDRESS (If rural, give location) <u>624 South 16th Street</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>624 South 16th Str.</u> | | | |

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|-------------------------------------|---------------------------|----------------------|-------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>William</u> | b. (Middle) <u>J</u> | c. (Last) <u>Dalton</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 19 1949</u> |
|-------------------------------------|---------------------------|----------------------|-------------------------|---|

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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Sept. 17, 1896</u> | 9. AGE (If years last birthday) <u>52</u> | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 HRS. Hours | IF UNDER 1 HRS. Min. |
|--------------------|-------------------------------|---|--|---|------------------------|----------------------|-----------------------|----------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Auto Business</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Business</u> | 11. BIRTHPLACE (State or foreign country) <u>Chariton, Iowa</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>John W. Dalton</u> | 13b. MOTHER'S MAIDEN NAME <u>Nora Murphy</u> | 14. NAME OF HUSBAND OR WIFE <u>Lillian B.</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | If yes, give war or dates of service <u>W.W.#1</u> | 16. SOCIAL SECURITY NO. <u>073-03-2152</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Lillian B. Dalton</u> | ADDRESS <u>624 So. 16th.</u> |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Alcoholic Poisoning</u> | | <u>3 weeks</u> |
| | ANTECEDENT CAUSES DUE TO (b) <u>Chronic Alcoholism</u> DUE TO (c) <u>Acute Gastric Hemorrhage</u> | | <u>1 yr</u> <u>1 yr</u> |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fatty Degeneration of Liver</u> | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|----------------------------------|--|

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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>3222</u> |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR |
|---|--|---------------------------|

22. I hereby certify that I attended the deceased from on 8/22, 1949, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:01 P. m., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) <u>H F Mundy M.D. Coroner</u> | 23b. ADDRESS <u>St. Joseph, Mo.</u> | 23c. DATE SIGNED <u>8/20/49</u> |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>8/22/1949</u> | 24c. NAME OF CEMETERY OR CREMATORY. <u>Mt. Olivet Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u> |
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| DATE REC'D BY LOCAL REG. <u>Aug 25, 1949</u> | REGISTRAR'S SIGNATURE <u>E. G. Jenkins</u> | 382 | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman W. Eidenhaden</u> | ADDRESS <u>1802 Union St. St. Joseph Mo.</u> |
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(Licensed Embalmer's Statement on Reverse Side)

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

AUG 20 1949

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 by _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed _____

Robert L. Gaylor

Licensed Embalmer No. 3308

P. O. Address 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.