

FILED APR 21 1945

Registration District No. 22

Primary Registration District No. 1000

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
524 North 29th  
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County De Falt

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

(d) Street No. 32  
(If rural, give location)

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

3. (a) PRINT FULL NAME Arthur P. Hall

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex male 5. Color or race White

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

6. (b) Name of husband or wife.....

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

7. Birth date of deceased January 17 1876  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>2</u>	<u>28</u>	..... hr. .... min.

9. Birthplace Sciota Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation gardner & teamster

11. Industry or business.....

12. Name David Hall

13. Birthplace Macomb Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Mary F. Folks

15. Birthplace unknown Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. P. E. Littles

(b) Address 524 North 29th

17. (a) burial (b) Date thereof 4/17/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Star, Mo.

18. (a) Signature of funeral director Nelson Belle & Bowman

(b) Address 319 So. 10th

19. (a) 4/16/45 (b) John J. Decker  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15  
year 1945 hour 11 minute A M

21. I hereby certify that I attended the deceased from April 5th  
1945 to April 15th, 1945  
that I last saw him alive on April 15, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Chronic Mys. Carditis 1 year  
Due to Chronic Asthma 1 year

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy no 930

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 0

23. Signature H F Mundy (M. D. or other).....  
Address 404 So 3d St Date signed 4/16/45

Duration

Underline the cause to which death should be charged statistically.

1377

APR 2 1948

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 \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

*Gerald I. Wade*

Licensed Embalmer No.

*4172*

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.

*Approved by \_\_\_\_\_*