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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33130

FILED OCT 22 1945

State File No. \_\_\_\_\_

Registration District No. 9942

Primary Registration District No. 53501000

Registrar's No. 58

1. PLACE OF DEATH:

(a) County Buchanan Co.

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

(c) Name of hospital or institution: mo. Meth. Hospital  
(If not in hospital or institution, write street number or location)

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

In this community ✓

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Buchanan

(c) City or town St Joseph mo  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Gerald Emory Birt

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 22 year 1945 hour 9:40 minute P M.

21. I hereby certify that I attended the deceased from 4-30 1945, to \_\_\_\_\_ 19\_\_\_\_; that I last saw him alive on 7-22 1945 and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced ○

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: 7 (Month) 22 (Day) 45 (Year)

Immediate cause of death: Hydrocephalus

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

8. AGE: Years Months Days If less than one day

2 22 hr. min.

9. Birthplace St Joseph mo (City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Emory Birt

13. Birthplace Dakota Co (City, town, or county) (State or foreign country)

14. Maiden name Nadine Kiefer

15. Birthplace Savannah mo (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Chas Birt

(b) Address Clarkdale

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof 7 23 45 (Month) (Day) (Year)

(c) Place: burial or cremation Clarkdale mo

18. (a) Signature of funeral director John Bran

(b) Address Marysville mo

19. (a) Aug 8 - 1945 (b) John Clarke (Date received local registrar) (Registrar's signature)

23. Signature H. A. Kearny (M. D. or other)

Address St Joseph mo Date signed 7-23-45

1428 (Licensed Embalmer's Statement on Reverse Side)

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

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.....

*John Brown*

Licensed Embalmer No. 3983

P. O. Address Wayneville, Va

**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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1102

Registration District No. 42 Primary Registration District No. 1000

Registrar's No. 8  
Local Reg. no. 1138

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:  
Mo. Meigs Hosp  
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution 2 mo. 22 da  
(Specify whether years, months or days)

In this community 2 mo. 22 da

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Buchanan

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

(d) Street No. Mo made Hwy (Parent's home at Clarkdale)  
(If rural, give location)

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

3. (a) PRINT FULL NAME Herald Emory Birt

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if live, 1945 \_\_\_\_\_

7. Birth date of deceased April 30, 1913  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St Joseph, MO  
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name Emory Birt

13. Birthplace De Kalb Co MO  
(City, town, or county) (State or foreign country)

14. Maiden name Nadine Knicker

15. Birthplace Savannah, MO  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Char Birt

(b) Address Clarkdale

17. (a) (Burial, cremation or inquest) \_\_\_\_\_ (b) Date thereof 7-23-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Clarkdale, MO

18. (a) Signature of funeral director John Bram

(b) Address Marysville, MO

19. (a) Oct. 24, 1945 (Date received local registrar)

(b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 22, 1945 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from July 22, 1945 to July 22, 1945; that I last saw him July 22, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Hydrocephalus Duration 4 hrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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)

(f) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) MO

Address St Joseph, MO Date signed 7-23-45

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

MOTHER FATHER

**MISSOURI DEPARTMENT OF HEALTH**

**STATE BOARD OF HEALTH**

**ST. JOSEPH, MISSOURI**

33130