

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

11662

**1. PLACE OF DEATH**

County Buchanan

Registration District No. 85

Township

City St Joseph Mo (No. 4)

Primary Registration District No. 1001

State Hospital #2.

File No.

Registered No. 339

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

Ward. Maryville, Mo.

(If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

Male

**4. COLOR OR RACE**

White

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Married

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

unknown

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

Unknown  
about 1854

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

about 78

Unknown

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

Not known  
Not known 31

**10. NAME OF FATHER**

unknown

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

unknown

**12. MAIDEN NAME OF MOTHER**

unknown

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

unknown

**14. INFORMANT**

(Address)

Records State Hosp #1  
St Joseph Mo

**15.**

APR

8 1932

John R. Bender  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

April 6 1932

I HEREBY CERTIFY, That I attended deceased from

June 27 1931 to April 6 1932

that I last saw him alive on April 6 1932, and that death occurred, on the date stated above, at 5:18 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic myocarditis  
over (duration) 9 yrs. 9 mos. 9 ds.

**CONTRIBUTORY (SECONDARY)**

Senile Dementia  
over (duration) 9 yrs. 9 mos. 9 ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

Dr. Clayton Smith M. D.

4/6/32 (Address)

State Hospital #1  
St Joseph Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

State Hospita Cemetery

**DATE OF BURIAL**

Apr, 8, 1932

**20. UNDERTAKER**

Walter Meierhoffer 1702 Faraon St. Joseph, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAY 28 1932

