

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.

SEP 18 1935

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

Do not use this space.

25876

1. PLACE OF DEATH  
 County Buchanan Registration District No. 85  
 Township \_\_\_\_\_ Primary Registration District No. 1001  
 City St. Joseph (No. State Hosp. # 2) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME William Mount  
 (a) Residence, No. St. Joseph, Mo. St. Ward \_\_\_\_\_  
 (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.

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) About 1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
about 82 Unknown

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Joseph, Mo.

13. NAME Mathias Mount

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky Auburn Kentucky

15. MAIDEN NAME E. Elizabeth Buchanan

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown unknown

17. INFORMANT (ADDRESS) State Hosp. Record St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Auburn DATE Aug. 30. 1935

19. UNDERTAKER (ADDRESS) FLEEMAN MORTUARY, INC. 1946 Calhoun St.

20. FILED 8-29 1935 John K. Bender Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 28 1935

22. I HEREBY CERTIFY, That I attended deceased from March 4, 1935 to Aug. 28 1935  
 I last saw him alive on Aug. 28 1935. Death is said to have occurred on the date stated above, at 4:45 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Chronic Myocarditis 3/4/34  
Thrombotic Atheroblastic 8/26/35  
hypertension

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) Dr. Charles S. Smith M. D.  
 (Address) State Hosp # 2 St. Joseph Mo

