

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

35594
Do not use this space.

1. PLACE OF DEATH *175* Buchanan / Registration District No. *85*
 (a) County *Buchanan* / Primary Registration District No. *1001*
 (b) Township _____ /
 (c) City *St. Joseph* / (d) Street No. *Mercy Hospital* St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred _____ yrs. mos. ds. (f) How long in U. S., if of foreign birth? _____ yrs. mos. ds.
 Elizabeth Jean Compton
 2. PRINT FULL NAME _____
 (a) Residence, No. *803 E. Hyde Park Ave.* St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct. 28, 1939*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
0 0 0
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Infant*
 9. Industry or business in which work was done, as 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) *St. Joseph*
 (STATE OR COUNTRY) *Missouri* *0*
 FATHER 13. NAME *Oscar Dale Compton* *0*
 14. BIRTHPLACE (CITY OR TOWN) *St. Joseph* *0*
 (STATE OR COUNTRY) *Missouri*
 MOTHER 15. MAIDEN NAME *Gertrude Wright*
 16. BIRTHPLACE (CITY OR TOWN) *St. Joseph*
 (STATE OR COUNTRY) *Missouri*
 17. INFORMANT *Oscar Dale Compton*
 (ADDRESS) *803 E. Hyde Park Ave.*
 18. BURIAL, CREMATION, OR REMOVAL
 PLACE *Memorial Park Cem.* DATE *Oct. 30, 1939*
 19. FUNERAL DIRECTOR (NAME) *Clark Mortuary*
 (ADDRESS) *5025 King Hill Ave.*
 20. FILED *10/30 1939* *H. J. Nestle*
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct. 28, 1939* 19
 22. I HEREBY CERTIFY, That I attended deceased from *10-28* 19*39*, to *10-28* 19*39*
 I last saw him alive on *10/28 9:30 a.m.* 19*39*. Death is said to have occurred on the date stated above, at *9:30 a.m.*
 The principal cause of death and related causes of importance were as follows:
 Date of onset
Asphyxia neonatorum
Compression of cord
 Other contributory causes of importance: *161 d*
 Name of operation _____ Date of _____
 What test confirmed diagnosis? *Clinical* 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) *H. J. Nestle* (Address) *873 Walnut St.*

(Licensed Embalmer's Statement on Reverse Side)

WHITE 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.

11
5
7

1 X1603

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, ~~on~~ Oct. 28, 1939

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

Signed Eric A. Clark

Licensed Embalmer No. 3476

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, above space should be left blank.