

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.

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

35601
 Do not use this space.

1. PLACE OF DEATH
 (a) County BUEHANAN Registration District No. 35
 (b) Township WASHINGTON Primary Registration District No. 1001 Registered No. 1122
 (c) City ST. JOSEPH (d) Street No. MO. METHODIST 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 24 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME GEORGE AMICK
 (a) Residence, No. 113 W HYDE PARK 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAR. 24-1883

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>56</u>	<u>7</u>	<u>6</u>	<u>10</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. BUTCHER
 9. Industry or business in which work was done, as saw mill, bank, etc. PACKING HOUSE
 10. Date deceased last worked at this occupation (month and year) OCT. 24, '39
 11. Total time (years) spent in this occupation 24

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MOORSVILLE MO

FATHER	13. NAME <u>LEONARD AMICK</u>
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>UNKNOWN MO</u>
MOTHER	15. MAIDEN NAME <u>HOLDA MANN</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>UNKNOWN</u>

17. INFORMANT MRS. MOLLIE AMICK
 (ADDRESS) 113 W HYDE PARK

18. BURIAL, CREMATION, OR REMOVAL PLACE 200 F Cemetery DATE Nov 1 1939

19. FUNERAL DIRECTOR (NAME) JOHN E RUPP
 (ADDRESS) 603 21st St ST. JOSEPH MO

20. FILED 10/31 1939 H. J. Neel
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-30-1939

22. I HEREBY CERTIFY, That I attended deceased from 10-25-39, 19....., to 10-30-, 1939
 I last saw him alive on 10-30-, 1939 Death is said to have occurred on the date stated above, at 4:30 P.M.
 The principal cause of death and related causes of importance were as follows:
Cancer of stomach Date of onset 5/19/1938
4/10

Other contributory causes of importance:
Thrombophlebitis 10-20-39
Operation resection of pyloric end of stomach
 Name of operation pyloric end of stomach Date of 10-30-39
 What test confirmed diagnosis? Lab 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) Paul Ferguson, M. D.
 (Address) St. Joseph, Mo

70006

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 E. Rupp

Licensed Embalmer No. 3486

P. O. Address St Joseph

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.