

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 83

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:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether
In this community 1 year 5 mo. 5 days
years, months or days)

FILED FEB 12 1940

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. 6529 Lake Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Larry Pflugradt 426

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

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

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

7. Birth date of deceased Aug. 19 1938
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 5 5 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Andrew Pflugradt

13. Birthplace St. Joseph Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Lillie Simpson

15. Birthplace St. Joseph Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Andrew Pflugradt

(b) Address 6529 Lake Ave. St. Joseph, Mo.

17. (a) Burial (b) Date thereof Jan 26th 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director FLEEMAN & SON, INC.

(b) Address 1946 Calhoun St. Joseph, Mo.

19. (a) 426/40 (b) [Signature]
(Intercoastal Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 24th
year 1940 hour 3 minute A.M.

21. I hereby certify that I attended the deceased from JAN. 22nd
1940, to JAN. 23rd, 1940
that I last saw him alive on JAN. 23rd, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: SPASMOPHILIA 1 DAY
UPPER RESPIRATORY INFECTION 1 WEEK

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

Major findings: Of operations no op
Of autopsy none

Duration
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) _____
As Means of injury _____

23. Signature [Signature] (M. D. or other) 85
Address 6207 Knight Hill Ave. Date signed 1/25/40

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 C. G. Swan

Licensed Embalmer No. 4082

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.