

FEB MAR 11 1940

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

5932
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
(b) Township St Joseph Primary Registration District No. 1001 Registered No. 132
(c) City St Joseph (d) Street No. Mo. Meth 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 11 yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 1214 FARRAGUT St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>MALE</u>	4. COLOR OR RACE <u>WHITE</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>WIDOWED</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>(Unk)</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>MAY-22ND 1861</u>		
7. AGE	YEARS <u>78</u>	MONTHS <u>8</u>
	DAYS <u>12</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>(Unk)</u>	
	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)	<u>PEORIA, ILL.</u>	
FATHER	13. NAME <u>JOSEPH HALEY</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>PEORIA ILL.</u>	
MOTHER	15. MAIDEN NAME <u>UNKNOWN</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>UNKNOWN</u>	
17. INFORMANT (ADDRESS) <u>PERSONAL RECORDS</u> <u>NO RELATIVES</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>CITY CEMETERY</u> DATE <u>FEB 7th 1940</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>FLEEMAN & SON INC</u> <u>1946 CALHOUN ST Joseph Mo</u>		
20. FILED <u>Feb. 7 1940</u> <u>HJ Nestel</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) FEB. 4th 1940

22. I HEREBY CERTIFY, That I attended deceased from 1-27, 1940, to Feb. 4, 1940
I last saw h. im alive on 2-4, 1940. Death is said to have occurred on the date stated above, at 4:20 P.M.
The principal cause of death and related causes of importance were as follows:
Myocardial failure
Date of onset 1/31

Other contributory causes of importance:
Debrisitis Chronic
Seminility
Arteriosclerosis

Name of operation no Date of no
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 no
Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify Chronic Myocardial _____, M. D.
(Signed) St Joseph Mo
(Address) 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.

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.....

R. V. Kerst

Licensed Embalmer No. *3876*

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.