

11
5
7

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: Mo. MEN'S Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 DAYS!
(Specify whether years, months or days)

In this community 4-5 YEARS

8. (a) PRINT FULL NAME ERNEST WILTON

8. (b) If veteran, name war _____

8. (c) Social Security No. NONE

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: Nov. 1874 1883
(Month) (Day) (Year)

8. AGE: Years 56 Months 2 Days 20
If less than one day hr. min.

9. Birthplace: SEYMOUR Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation CLERK

11. Industry or business _____

12. Name UNKNOWN

13. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. BLANCHE ADAIR

(b) Address 109 E. AUGUSTA St. JOSEPH

17. (a) BURIAL (b) Date thereof FEB. 12 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. AUBURN

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

(b) Address 1946 CALHAN St. JOSEPH

19. (a) Feb. 13, 1940 (b) H. J. Neel
(Date received local registrar) (Registrar's signature)

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. MEN'S BUREAU 108 N. 2nd
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB. day 8th.
year 1940 hour 6 minute 25 PM.

21. I hereby certify that I attended the deceased from 1-17, 1940, to 2-8, 1940;
that I last saw him alive on 2-8, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia

Due to Following cholelithiasis 1-27-40
Arteriosclerosis of Aorta

Due to Heart Disease - Chronic

Other conditions: _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: SEE ABOVE

Of operations _____

Of autopsy No

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? 85 (Specify type of place) _____

(e) Means of injury _____

23. Signature Very a Neely (M. D. or other) _____

Address High Bldg. Date signed 2-12-40

12412

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. S. Swan

Licensed Embalmer No. 1082

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3947

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 148

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community. (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Ernest Milton

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, divorced, or married

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

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 56 Months 2 Days 20 If less than one day hr. min.

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

10. Usual occupation.

11. Industry or business.

12. Name.

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

14. Maiden name. (City, town, or county) (State or foreign country)

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

16. (a) Informant.

(b) Address.

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

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) 4/11/40 (Date received local registrar) (b) Registrar's signature

2. USUAL RESIDENCE OF DECEASED:

(a) State. (b) County.
(c) City or town. (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month Feb day 8 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic Pneumonia Following Cholecystectomy Cirrhosis of Liver
Due to Heart Disease Chronic
Other conditions: Cholecystitis #

Major findings: see above
Of operations: 124
Of autopsy:

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) (e) Means of injury.

23. Signature Owen W. Craig (M. D. or other) Address: St Joseph, Mo. Date signed.

SUPPLEMENTAL

