

BUREAU OF THE CENSUS
FILED MAR 11 1940
85

Registration District No.

Primary Registration District No. 100f

Registrar's No.

11597
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Methodist Hosp. †
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME WAYNE ELBERT FLOREA.

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive NONE years

7. Birth date of deceased. Jan 19 1940
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 26. If less than one day hr. _____ min. _____

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

10. Usual occupation none

11. Industry or business none

12. Name ORLIN FLOREA 6

13. Birthplace HOPKINS Mo. 6
(City, town, or county) (State or foreign country)

14. Maiden name MARGARET KING

15. Birthplace HOPKINS Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant ORLIN FLOREA

(b) Address HOPKINS MO

17. (a) HOPKINS MO. (b) Date thereof FEB 14 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HOPKINS CEMETERY

18. (a) Signature of funeral director Thermon & Son Inc.
(b) Address 1946 Colborn - St. Joseph Mo.

19. (a) 2/14/40 (b) H. J. Keith
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County No. Laway

(c) City or town Hopkins Mo. RURAL.
(If outside city or town limits, write "RURAL")

(d) Street No. TWO MILES EAST OF TOWN.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? NONE years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 14
year 40 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from 2/14/40, 1940, to 2/14/40, 1940
that I last saw him alive on 2/14/40, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital deformities

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 1575

Major findings: Of operations ✓ Of autopsy ✓

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? _____

(Specify type of place) _____ (e) Means of injury _____

23. Signature Charles Jean Boeg (M. D. or other) 1
Address PHYS. & SURG BLDG Date signed _____
St. Joseph Mo.

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.