

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.

MAY 13 1940

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

14320  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Buchanan Registration District No. 85  
 (b) Township \_\_\_\_\_ Primary Registration District No. 1001 Registered No. 408  
 (c) City St. Joseph (d) Street No. 416 N. 2nd, St. 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
 2. PRINT FULL NAME Samuel Alexander  
 (a) Residence, No. 416 N. 2nd, St. 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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Caroline Alexander  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2/2/1864  
 7. AGE YEARS 76 MONTHS 2 DAYS 5 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Common Laborer  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 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) Lexington, Kentucky  
 FATHER 13. NAME Unknown  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
 MOTHER 15. MAIDEN NAME Unknown  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
 17. INFORMANT Mrs. Ruth Alexander  
 (ADDRESS) 713 Pendleton  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Mora Cemetery DATE 4-12-'40  
 19. FUNERAL DIRECTOR Graves Funeral Home  
 (ADDRESS) 806 S. 17th, St.  
 20. FILED 4/12 1940 W. J. Nestlebusch  
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 7, 1940<sup>19</sup>  
 22. I HEREBY CERTIFY, That I attended deceased from March 15 1940 to April 7 1940  
 I last saw him alive on March 15 1940 Death is said to have occurred on the date stated above, at 1:50 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Mitral Regurgitation  
Chronic Nephritis  
 Date of onset Not known  
 Other contributory causes of importance:  
None  
 Name of operation Chronic Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ 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) W. J. Nestlebusch M. D.  
 (Address) 109 1/2 W. Mo. Ave

STATEMENT BY LICENSED EMBALMER

I, A. T. Moore, Licensed Embalmer No. 948

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me

L. E.

No. 948 or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

*A. T. Moore*

Licensed Embalmer No. 948

**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.)**