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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21217

Registration District No. 85 JUL 2 1940

Primary Registration District No. 1001

Registrar's No. 616

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: 608 Lincoln Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community Twenty years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town Saint Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 608 Lincoln Street
(If rural, give location)

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

3. (a) PRINT FULL NAME John Chancy Case

3. (b) If veteran, name war —

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mrs. Minnie E. Case

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased January (Month) 6 (Day) 1862 (Year)

8. AGE: Years 78 Months 4 Days 26 If less than one day ____ hr. ____ min.

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

10. Usual occupation Grocer at 1224 No. 6th St

11. Industry or business

FATHER
12. Name Orsen Case
13. Birthplace Akron, (City, town, or county) Ohio (State or foreign country)

MOTHER
14. Maiden name Mary Ann Bond
15. Birthplace Unknown (City, town, or county) Indiana (State or foreign country)

16. (a) Informant Ben Case
(b) Address 519½ Messanie Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June (Month) 3 (Day) 1940 (Year)
(c) Place: burial or cremation Mt. Mora Cemetery

18. (a) Signature of funeral director Mrs. E. R. Sidenfaden F. Home
(b) Address 602 South 10th Street

19. (a) June 3 1940 (Date received local registrar) (b) S J Wattebush (Registrar's signature) X 5

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2nd year 1940 9 hour 9 minute P. M.

21. I hereby certify that I attended the deceased from May, 1939, to June 2, 1940; that I last saw him alive on February 16, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Complete cessation of cardiac function.

Due to Acute endocarditis

Due to Generalized arteriosclerosis

Other conditions Cancerous prostate
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature L. E. Stevenson ~~(M. D.~~ or other) D. O.
Address 801 ½ Francis Date signed 6-3-40

(Licensed Embalmer's Statement on Reverse Side)

58

801 Fran

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

Mollie E. Sidenfaden, Registered Apprentice No. 145

working under my personal supervision.

Signed R V West

Licensed Embalmer No. 3876

P. O. Address St Joseph M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21217

Registration District No. 86 Primary Registration District No. 1001 Registrar's No. 616

SUPPLEMENTARY

8/1/91

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

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.

3. (a) PRINT FULL NAME: John Chaney Case
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: widowed
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years | Months | Days | 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 (FATHER)
13. Birthplace (City, town, or county) (State or foreign country) (FATHER)
14. Maiden name (MOTHER)
15. Birthplace (City, town, or county) (State or foreign country) (MOTHER)
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) Aug. 20, 1940 (Date received local registrar) (b) H. Westbrook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2d year 1940 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.
Immediate cause of death: Complete-cerebellation of Carotine function — Duration
Due to: acute Endo Condition
Due to:
Other conditions (Include pregnancy within 3 months of death): Generalized sclerosis
Major findings: Of operations: Carcinoma of prostate, posterior
Of autopsy: Lymphadenoma of prostate 51

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? (Specify type of place)
While at work?
(e) Means of injury
23. Signature: B. E. Stevenson (M. D. or other)
Address: St Joseph Date signed

[redacted]