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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED JUL 15 1940

State File No. 21254

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 659

1. PLACE OF DEATH:

(a) County Buchanan 1 0

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

(c) Name of hospital or institution: St Joseph's Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days (Specify whether

In this community 26 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

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

(d) Street No. 919 West Hyde Park (If rural, give location)

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

3. (a) PRINT FULL NAME Jacob L. Breshears 626

3. (b) If veteran, name war ✓

3. (c) Social Security No. 500-07-6693

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Norma

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased March 16 (Month) 1885 (Day) (Year)

8. AGE: Years 55 Months 3 Days 0 If less than one day hr. min.

9. Birthplace Dallas County Mo 0 (City, town, or county) (State or foreign country)

10. Usual occupation Laborer 9

11. Industry or business

FATHER
12. Name Calvin Breshears 0
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Catherine Silkey
15. Birthplace Dallas County Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Norma Breshears

(b) Address 919 West Hyde Park

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation C O O F Cemetery

18. (a) Signature of funeral director Tracy Barry Funeral Home

(b) Address 218 South 10th St

19. (a) 6/18/40 (Date received local registrar) (b) H J Mostlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16 th year 1940 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from June 5, 1940, to June 16, 1940 that I last saw him alive on June 16, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Obstruction of bowel	12 hrs.
Due to: Incisional hernia (post-operative)	20 yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations Herniaplasty 6/6/40

Of autopsy Obstruction of bowel

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 Owen W N Craig (M. D. ~~or other~~) MD

Address Kirkpatrick Bldg Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 John E. Myers

Licensed Embalmer No. 3220

P. O. Address St. Joseph, Mo.

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

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