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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24696

AUG 10 1940

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 821

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: STATE HOSPITAL No. 2
(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 years, 9 months, 2 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.: Unknown
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME: Alice Parker Black
3. (b) If veteran, name war: none
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: William W. Black
6. (c) Age of husband or wife if alive: 70 years
7. Birth date of deceased: ? (Month) ? (Day) ? (Year)

8. AGE: Years	Months	Days	If less than one day
Est. 70	?	?	..... hr. ..... min.

9. Birthplace: (Unk) (City, town, or county) (Unk) (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: ?
FATHER
12. Name: (Unk)
13. Birthplace: ? (City, town, or county) ? (State or foreign country)
MOTHER
14. Maiden name: ?
15. Birthplace: ? (City, town, or county) ? (State or foreign country)
16. (a) Informant: Welfare Board
(b) Address: Community Hall, St. Joseph, Mo.
17. (a) Kirksville, Mo. (Burial, cremation, or removal) (b) Date thereof: 7/31/40 (Month) (Day) (Year)
(c) Place: burial or cremation: Kirksville, Mo.
18. (a) Signature of funeral director: Summers and Flinchnaugh
(b) Address: Kirksville, Mo.
19. (a) 7/31/40 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28 year 1940 hour 1 minute 30 P.M.
21. I hereby certify that I attended the deceased from April 16, 1940 to July 28, 1940 that I last saw her alive on July 28, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Postoperative Bronchopneumonia (Organism unknown)	7-26-40
Due to:	
Due to:	
Other conditions: Diabetes mellitus (Include pregnancy within 3 months of death)	

Major findings:
Of operations: Ventral Hernia - operated 7-25-40
Of autopsy: not done

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: D. P. Johnson M.D. (M. D. or other) 1
Address: State Hosp. #2, St. Joseph, Mo. Date signed: 7-31-40

(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 E T Whitaker, Registered Apprentice No. ..... working under my personal supervision.

Signed W L Simmons

Licensed Embalmer No. 2159

P. O. Address Kittsville Me

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, fact should be so stated above.