

S. No. 2
-11-10-39
v. 5-17-39
I X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28007**
Registrar's No. **911**

Registration District No. **85** Primary Registration District No. **1001**

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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: **MO. METHO. HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days**
In this community **673** years, months or days (Specify whether)

3. (a) PRINT FULL NAME **Dean Kumbel Markt**
3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mary Joe Markt** 6. (c) Age of husband or wife if alive **22** years
7. Birth date of deceased **May 1 1916** (Month) (Day) (Year)

8. AGE: Years **24** Months **3** Days **18** If less than one day hr. min.

9. Birthplace **Oregon** (City, town, or county) **Mo** (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **General Farming**

12. Name **Wesley W. Markt**
13. Birthplace **Oregon** (City, town, or county) **Mo** (State or foreign country)
14. Maiden name **Charlene Kumbel**
15. Birthplace **Holt County** (City, town, or county) **Missouri** (State or foreign country)

16. (a) Informant **Wesley W Markt**
(b) Address **Oregon Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Aug 21 1940** (Month) (Day) (Year)
(c) Place: burial or cremation **Oregon Mo**

18. (a) Signature of funeral director **James H Pettyjohn**
(b) Address **Oregon Mo**

19. (a) **819 1/2 N. 7th St. St Joseph** (Date received local registrar) **[Signature]** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **0 Missouri** (b) County **Holt**
(c) City or town **Rural** (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **19** year **1940** hour **5** minute **00** A. M.
21. I hereby certify that I attended the deceased from **Aug - 16** 19**40**, to **Aug - 19** 19**40**
that I last saw him alive on **Aug - 18 - 40** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Typhoid Fever** Duration
Due to
Due to
Other conditions **Appended appendix & abscess** (Include pregnancy within 3 months of death)

MAJOR FINDINGS: **Appendix abscess**
Of operations **was reported**
Of autopsy **no**

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) **no**
(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?
85 (Specify type of place) (e) Means of injury
23. Signature **L. R. Howden M.D.** (M. D. or other) **M.D.**
Address **620 Franklin St. St Joseph** Date signed **8-19-40**

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 James H. Pettigrew
Licensed Embalmer No. 3192
P. O. Address Oregon Mo.

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.