

No. 2
4-12-40
1-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31421**
Registrar's No. **975**

FILED OCT 10 1940
Registration District No. **1001**

Primary Registration District No. **1001**

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: **Sunnyslope Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days**
In this community **15 years.** (Specify whether years, months or days)

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

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive **9th** years
7. Birth date of deceased **January 9th 1925**
(Month) (Day) (Year)

8. AGE: Years **15** Months **7** Days **26**
If less than one day hr. min.

9. Birthplace **S. Joseph Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Student**

11. Industry or business **Pickett School**

12. Name **Albert Fuellgraf**

13. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Ann Kenney**

15. Birthplace **Mountain Grove Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Albert Fuellgraf**

(b) Address **R.F.D.#1 St. Joseph, Mo.**

17. (a) **Burial** (b) Date thereof **Sept. 6, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Ashland Cemetery**

18. (a) Signature of funeral director **H.O. Sidenfaden & Son**
1802 Union Str. St. Joseph, Mo.
(b) Address
19. (a) **Sept. 5, 1940** (b) **AJ Resdehual**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Buchanan**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **R.F.D.#1 St. Joseph, Mo.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept.** day **5th**
year **1940** hour **10** minute **20** AM

21. I hereby certify that I attended the deceased from **Aug 30** to **Sept 5**, 19**40**,
that I last saw him alive on **Sept 5**, 19**40**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia ascending**
Duration **Aug 28/40**

Due to **ascending**
Due to

Other conditions **16**
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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?

8.5 (Specify type of place)
While at work (e) Manner of injury
23. Signature **Paul H. Hartigan** (M. D. or other)
Address **Empire State Bldg** Date signed **9/5/40**

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..... *Robert P. Clarkson*.....

Licensed Embalmer No. 4028.....

P. O. Address St. Joseph, 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, fact should be so stated above.