

2-40  
7-39  
X23159

Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County BUCHANAN  
(b) City or town ST. JOSEPH  
(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 11 ds.  
In this community no information 11 days  
years, months or days) (Specify whether 3)

3. (a) PRINT FULL NAME Theodore Carl  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex male 5. Color or race white 6. (a) Single, widowed, divorced, widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive deceased years  
7. Birth date of deceased 1850  
(Month) (Day) (Year)

8. AGE: Years 90 Months ? Days ? If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

12. Name no information

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Myrtle Meier

(b) Address 133 N. Quincy, B. C. Mo.

17. (a) Burial (b) Date of removal Nov. 27, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director H.C. Sidenfaden & Son

(b) Address 1802 Union Str. St. Joseph, Mo.

19. (a) 11-27-1940 (b) 29 Nestlebrush  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Fairmont  
(If outside city or town limits, write "RURAL")  
(d) Street No. 104 N. Wilson  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26  
year 1940 hour 3-15 minute 2 M.

21. I hereby certify that I attended the deceased from Nov. 15, 1940 to Nov. 26, 1940  
that I last saw him alive on Nov. 26, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardosis  
Due to Arteriosclerosis

Duration

?  
?

Due to \_\_\_\_\_  
Other conditions (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? 85  
(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. J. O'Neil (M. D. or other) Mo.  
Address St. Joseph Date signed 12/26/40

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

REC-10048

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**