

Registration District No. **85**

Primary Registration District No. **1001**

11
57

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

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 days**
 In this community **all of life 11 days**

3. (a) PRINT FULL NAME **Steven A. Christison**
 (b) If veteran, name war _____ (c) Social Security No. _____

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 _____ years
 7. Birth date of deceased **mar. 28, 1863**
 (Month) (Day) (Year)

8. AGE: Years **77** Months **8** Days **17** If less than one day hr. min.

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

10. Usual occupation **farming**

11. Industry or business _____
 12. Name **Lenard Christison**
 13. Birthplace **Va.**
 14. Maiden name **Martha Oliver**
 15. Birthplace **UNKNOWN Ky.**

16. (a) Informant **Mrs. W. L. Wray**
 (b) Address **Ubraton Mo.**

17. (a) **Removal** (b) Date thereof **12-16-40**
 (c) Place: burial or cremation **Phillip Crocker Mo.**

18. (a) Signature of funeral director **FLEEMAN & SON**
 (b) Address **St. Joseph, Mo.**

19. (a) **12/17/40** (b) **H. J. Heitler**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Livingston**
 (c) City or town **rural**
 (d) Street No. _____
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Dec.** day **15**
 year **1940** hour **5-30** minute **P.** M.

21. I hereby certify that I attended the deceased from **Dec. 4**, 1940, to **Dec. 15**, 1940
 that I last saw him alive on **Dec. 15**, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchio pneumonia**
 Due to **Arteriosclerosis**

Due to _____
 Other conditions **1070**
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 (Specify type of place) _____ (e) Means of injury _____

23. Signature **H. J. Heitler** (M. D. or other) _____
 Address **St. Joseph** Date signed **12/15/40**

Duration **1 week**
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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.....

Carl W. Hulse

Licensed Embalmer No. 3955

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.