

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 45

## 1. PLACE OF DEATH:

(a) County Buchanan  
 (b) City or town At Joseph  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
716 No 6th St 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community 74 years  
 years, months or days)

## 3. (a) PRINT FULL NAME

Melilah E Hagin3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex Female5. Color or  
race wh6. (a) Single, widowed, married,  
divorced Widow

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

7. Birth date of deceased Apr 22 1866  
(Month) (Day) (Year)

## 8. AGE:

Years

Months

Days

If less than one day

74819

hr. min.

## 9. Birthplace

Brown Co Kansas  
(City, town, or county) (State or foreign country)

## 10. Usual occupation

at home

## 11. Industry or business

MOTHER FATHER

## 12. Name

John Amano

## 13. Birthplace

Crawford Co Ohio  
(City, town, or county) (State or foreign country)

## 14. Maiden name

Walter Amano

## 15. Birthplace

Franklin Co Ky  
(City, town, or county) (State or foreign country)

## 16. (a) Informant

Mrs Herbert Gorden

## (b) Address

3609 Mitchell17. (a) Burial

(Burial, cremation, or removal)

## (b) Date thereof

7/12-1941  
(Month) (Day) (Year)

## (c) Place: burial or cremation

At home

## 18. (a) Signature of funeral director

J. H. Blumley

## (b) Address

2925 Mitchell19. (a) Jan 13, 1941

(Date received local registrar)

(b) J. H. Blumley

(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
 (c) City or town At Joseph  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 716 No 6th St  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 11  
 year 1941 hour 10 minute 30 PM

21. I hereby certify that I attended the deceased from 12-9-1940  
 , 1940, to 1-11, 1941

that I last saw her alive on 1-11, 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death

Cancer of  
Lungs and Bilary  
Passages

Duration

Due to \_\_\_\_\_

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 sta-  
tistically.

## 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

While at work? \_\_\_\_\_

(Specify type of place)

(a) Means of injury 0123. Signature Dr. C. W. Hunter (M. D. or other) 00Address 201 New Bldg Date signed 1-12-41

46

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. 1946 working under my personal supervision.

Signed J. H. [Signature]

Licensed Embalmer No. \_\_\_\_\_

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1815-  
Registrar's No. 45

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town Buchanan  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.  
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Delilah E. Hagin

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex 7

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-------|--------|------|----------------------|
|         | 74    | 8      | 19   | hr. min.             |

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

10. Usual occupation

11. Industry or business

12. Name

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

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Apr. 10 1941 (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County  
(c) City or town (If outside city or town limits write "RURAL")  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long U. S. A.? years

DEATH CERTIFICATION

20. DATE OF DEATH Month July day 11 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that last saw h. alive on and that death occurred on the date and hour stated above.

Immediate cause of death: Cancer of liver and Biliary Paralysis  
Internal hemorrhage 3 or 4 hrs

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?  
While at work? (Specify type of place) (c) Means of injury

23. Signature Dr. C. W. Foster (M. D. or other) Address 201 Main Bldg Date signed 4/9/41

SUPPLEMENTARY

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

MOTHER FATHER

11w 71g

