

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **545**

1. PLACE OF DEATH: Buchanan  
 (a) County Buchanan  
 (b) City or town St. Joseph  
 (c) Name of hospital or institution 1721 Bartlett St  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution none  
 In this community Whole Life Care Home  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State mo (b) County Buchanan  
 (c) City or town St. Joseph mo  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1721 Bartlett  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME John Stone  
 3. (b) If veteran name war no  
 3. (c) Social Security No. none

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month May day 22  
 year 1941 hour 9 minute 30 A. M.

4. Sex male 5. Color or race negro  
 6. (a) Single, widowed, married, divorced infant  
 6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive 0 years  
 7. Birth date of deceased May 22 - 1941  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 22  
1941, to May 22, 1941,  
 that I last saw him alive on May 22, 1941,  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>0</u>	hr. <u>0</u> min.

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

Immediate cause of death Pneumonia, Birt  
6 months  
 Duration

10. Usual occupation none  
 11. Industry or business none  
 12. Name unknown  
 13. Birthplace unknown 9  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Corene Stone  
 15. Birthplace St. Joseph mo  
 (City, town, or county) (State or foreign country)

Due to Secondary Erythra  
cy markers  
 Due to SA  
 Other conditions 10  
 (include pregnancy within 3 months of death)

MOTHER FATHER  
 16. (a) Informant Corene Stone  
 (b) Address 1721 Bartlett  
 17. (a) Burial (b) Date thereof 5/23/41  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation City Cemetery  
 18. (a) Signature of funeral director Samuel W. Spivey  
 (b) Address 1602 Mississippi  
 19. (a) May 24 - 1941 (b) A. J. Hatcher  
 (Date received local registrar) (Registrar's signature)

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) 85  
 (b) Date of occurrence 5-23-41  
 (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) (e) Means of injury  
 23. Signature J. D. Stryker (M. D. or other) M. D.  
 Address St. Joseph MO Date signed 5-23-41

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

**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.....

.....  
working under my personal supervision.

*Not Embalmed*  
*J.F. Ramsey*

....., Registered Apprentice No.....

Signed.....

..... Licensed Embalmer No.....

..... P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 195-99  
Registrar's No. 545

Registration District No. 85-

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Bachman  
(b) City or town St Joseph  
(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 \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME John Stone  
3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year

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

8. AGE:	Years	Months	Days	If less than one day
				<u>2</u> hr. <u>10</u> 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)  
(Date received local registrar)

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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Premature death 16 months During

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

Due to Inevitable

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) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature G.D. Sexton (M. D. or other) \_\_\_\_\_

Address St Joseph mo Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

19599