

AUG 11 1941 85
Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH: BUCHANAN
(a) County St. Joseph
(b) City or town St. Joseph
(c) Name of hospital or institution: Mercy Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 days
In this community unknown (Specify whether years, months or days)

3. (a) PRINT FULL NAME Bill-Airrie
(b) If veteran, name war _____ (c) Social Security No. NONE

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed
(b) Name of husband or wife Margaret-Airrie (c) Age of husband or wife if alive years 1849
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 92 Months 8 Days 8 If less than one day hr. min.

9. Birthplace Maryland, Ky-1 (City, town, or county) (State or foreign country)

10. Usual occupation Porter

11. Industry or business Barber Shop

12. Name James-Airrie

13. Birthplace Unknown Ky 1 (City, town, or county) (State or foreign country)

14. Maiden name Margaret

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

16. (a) Informant Dr. W. E. Avery

(b) Address 211-S-7th

17. (a) Burial (b) Date thereof 7-10-41 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City-Cemetery

18. (a) Signature of funeral director Graves

(b) Address 206-S-17th St

19. (a) July 9 1941 (b) [Signature] (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 011
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1717 1/2-S-8th St
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? 0 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 9 day July
year 1941 hour 10 minute 15 P. M.

21. I hereby certify that I attended the deceased from June 1, 1941
to July 8, 1941
that I last saw him alive on July 8, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Endocarditis
Senility-Chronic nephritis

Due to _____

Due to 17/8

Other conditions _____
(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? _____ (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) (Means of injury)

23. Signature [Signature] (M. D. or other) D.O.

Address 823 Farnham Street Date signed 7-8-41

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 MC

Registered Apprentice No. _____

working under my personal supervision.

Signed A. H. Moore

Licensed Embalmer No. 948

P. O. Address St. Joseph

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.