

OCT 21 1942

State File No. _____

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 945

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town Saint Joseph,
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Rosary Hill Nursing Home, 4
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 days
 (Specify whether years, months or days)
 In this community 29 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan,
 (c) City or town Saint Joseph,
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1603 St. Joseph Avenue,
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3rd.
 year 1942 hour 3:00 minute 40a. M.

21. I hereby certify that I attended the deceased from
Oct 2, 1942 to Oct 3, 1942
 that I last saw him alive on Oct 2, 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death mitral insufficiency
 Duration 4 yrs

Due to _____
 Due to _____

Other conditions Enlarged heart probably malignant
 (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 Q

23. Signature J R Elliott (M. D. or other) 798
 Address 801 1/2 Jones St Date signed 10/13/42

3. (a) PRINT FULL NAME William Parker Flint,

3. (b) If veteran, name war None, 3. (c) Social Security No. 438-14-8929

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

6. (b) Name of husband or wife Nettie Flint, 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased February Unk 1865
 (Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days Unk If less than one day hr. _____ min. _____

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

10. Usual occupation Packer,
Wholesale Dry Goods

11. Industry or business _____

12. Name Unknown,

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

14. Maiden name Unknown,

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

16. (a) Informant William O. Flint,

(b) Address 4401 Main Street, Kansas Cit,

17. (a) removal (b) Date thereof 10/4/42
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place; burial or cremation Dexter, Kansas,

18. (a) Signature of funeral director Arthur L. Bauman Funeral

(b) Address 319 So. 10th Street, Home

19. (a) 10-4-42 (b) Rose Herzig
 (Date received local registrar) (Registrar's signature)

1233

(Licensed Embalmer's Statement on Reverse Side)

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 Oct. 2, 194

....., Registered Apprentice No.
working under my personal supervision.

Signed Wm. E. Summerfield

Licensed Embalmer No. 3007

P. O. Address 319 So. 1. St Joseph M

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.

STANDARD CERTIFICATE OF DEATH

State File No. 33217

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 945

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rosary Hill Nursing Home
(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)

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 Oct Day _____
year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____
_____ 19____;
that I first saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above
Immediate cause of death initial insufficiency Duration _____

3. (a) PRINT FULL NAME Wm Parker Fleet
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years 72 Months 8 Days _____ If less than one day _____ 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 _____ (City, town, or county) _____ (State or foreign country)

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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

Due to _____
Due to _____
Other conditions enlarged glands
(Include pregnancy within 5 months of death)
probably malignancy
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature R. Elliott (M. D. or other) _____
Address Rock House at St Joseph mo. Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

