S. No. 2
M—5-42
5-17-39
P I X32873

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

33226

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 12 1942

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 849

11
1
7

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: St. Joseph's Hospital 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether

In this community 10 years, years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan 11 1

(c) City or town Saint Joseph, 7 (If outside city or town limits, write "RURAL")

(d) Street No. 308½ Felix Street, (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME John Gallitzin Henry

3. (b) If veteran, name war Unknown

3. (c) Social Security No. 491-22-5660

4. Sex Male

5. Color or race White 0

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased August (Month) Unk. (Day) 1878 (Year)

8. AGE:

Years	Months	Days	If less than one day
64	3	Unk.	hr. min.

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

10. Usual occupation unknown

11. Industry or business unknown

FATHER
12. Name unknown
13. Birthplace Unknown, (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown,
15. Birthplace Unknown, (City, town, or county) 9 (State or foreign country)

16. (a) Informant St. Joseph's Hosp. records,

(b) Address St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/42 (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery,

18. (a) Signature of funeral director Heston Bigold Bowman Funeral Home

(b) Address 319 So. 10th Street,

19. (a) 11-9-42 (Date received local registrar) (b) Rose Hagog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 1st. year 1942 hour 5:00 minute 22a. M.

21. I hereby certify that I attended the deceased from 10-28-42, 19, to 11-42, 19; that I last saw him alive on 10-31, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death bronchial pneumonia

Due to Flu - asthma syphilitic lesions

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none 30g

Of autopsy none

Duration

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) no

(b) Date of occurrence none

(c) Where did injury occur? none (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no (Specify type of place)

While at work? no (e) Means of injury no

23. Signature Aiglon Smith (M. D. or ~~other~~)

Address Welfare Board Date signed 11/5/42

1232

(Licensed Embalmer's Statement on Reverse Side)

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~~ Nov. 1. 42

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

working under my personal supervision.

Signed Wm E. Summerfield

Licensed Embalmer No. 3007

P. O. Address 3 A D 40 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.