

Registration District No. 9542

Primary Registration District No. 1001000

State File No.

Registrar's No. 17

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: State Hospital no. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 yrs. 8 mo. 13 da.
In this community 2 yrs. 8 mo. 13 da.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. North 31st
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 7
year 1943 hour 5 minute 5 P. M.

21. I hereby certify that I attended the deceased from Dec 31 - 1942 to Jan 7 1943
that I last saw him alive on Jan 7 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion Duration 1 hr.

Due to: Arterio Sclerosis 5 yr.

Due to:

Other conditions (include pregnancy within 3 months of death) None

Major findings: Of operations None

Of autopsy None

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 0

23. Signature Geo. M. Batiles (M. D. or other) 1/7/43
Address St. Joseph Mo. Date signed 1/7/43

Duration
1 hr.
5 yr.
PHYSICIAN
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME ANDREW C. SIFERS

3. (b) If veteran, name war 3. (c) Social Security No.

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

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

7. Birth date of deceased Dec 25 1863
(Month) (Day) (Year)

8. AGE: Years 79 Months 13 If less than one day hr. min.

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

10. Usual occupation Candy salesman

11. Industry or business

12. Name St. M. H. Sifers

13. Birthplace Cumberland Gap Tenn
(City, town, or county) (State or foreign country)

14. Maiden name Maudie Slaybaugh

15. Birthplace St. Albans Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital

(b) Address St. Joseph, Mo. no. 2

17. (a) R. (b) Date thereof Jan 10 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Indep. Cemetery

18. (a) Signature of funeral director J. G. Brown

(b) Address St. Joseph

19. (a) Jan 8 1943 (b) Rose Hayes
(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

MOTHER FATHER

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.....
working under my personal supervision.

Signed..... *F. G. Now*

Licensed Embalmer No. *952*

P. O. Address *Stewartville*

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.