

Regan & Johnson

DEPARTMENT OF COMMERCE - BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

13725

FILED MAY 13 1943

State File No. ....

Registration District No. ....

Primary Registration District No. 1000

Registrar's No. 527

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph

(c) Name of hospital or institution: Mo. Meth Hosp. 0

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 28 Days (Specify whether years, months or days) 28 Days

In this community 28 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew

(c) City or town Savannah

(If outside city or town limits, write "RURAL")

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

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

If yes, name country. /

3. (a) PRINT FULL NAME GEORGIANE C. HORTON

3. (b) If veteran, none

3. (c) Social Security No. NO

name war. No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3

year 1943 hour 7 minute 45 P. M.

21. I hereby certify that I attended the deceased from Oct 6 1942 to May 3 1943

that I last saw her alive on Aug 3 1943

and that death occurred on the date and hour stated above.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced 2 W

6. (b) Name of husband or wife WILLIAM R. HORTON

6. (c) Age of husband or wife if alive years 1882

7. Birth date of deceased Aug 3 1882

(Month) (Day) (Year)

Immediate cause of death Myocardial infarct. Cong. type 6 mo

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

60 9 - hr. min.

Due to Hypertension and type thyroidism

Due to

Other conditions (Include pregnancy within 3 months of death)

9. Birthplace SAVANNAH MO 0

(City, town, or county) (State or foreign country)

10. Usual occupation Housew. Pe.

11. Industry or business

12. Name WILLIAM DAVID CORMANBY

13. Birthplace Wythe Co VA /

(City, town, or county) (State or foreign country)

14. Maiden name LOUISA ELIZABETH SCHWARTZ

15. Birthplace No Record No Record

(City, town, or county) (State or foreign country)

16. (a) Informant Miss Helen Cormanby

(b) Address St. Joseph Mo

17. (a) Removal (b) Date thereof May 4 43

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah Missouri

18. (a) Signature of funeral director Howard J. Sidupaden

(b) Address 1802 Union, St. Joseph, Mo.

19. (a) 5-4-43 (b) Owe Geryog

(Date received local registrar) (Registrar's signature)

Major findings: Toxic state ✓

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)

(a) Means of injury. 0

23. Signature Dr. O. N. Johnson (M. D. or other) med

Address St. Joseph Mo Date signed 5-4-43

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

*Hereward L. Pidenford*

Licensed Embalmer No.

*2728*

P. O. Address

*Stephens 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 13725-  
Registrar's No. 527

Registration District No. 42 Primary Registration District No. 1000

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:  
Mo. Meek Hosp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 28 da (Specify whether  
In this community 28 da years, months or days)

3. (a) PRINT FULL NAME Georgiame C Norton  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 3 - 1888  
(Month) (Day) (Year)

8. AGE: Years 60 Months 9 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Therese Norton  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name Therese  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Adair  
(c) City or town Savannah (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 Aug Day 3 Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Myocardial Infarction  
type 6 mo.  
Due to hypertension  
hyperthyroidism  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Toxic Gastritis ✓  
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) (e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

