

Registration District No. 1000
1001

Primary Registration District No. 1000
1001

Registrar's No. 623

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. 5 mo. 9 da.
(Specify whether In this community 2 yrs. 3 mo. 9 da. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callowell
(c) City or town Wades (If outside city or town limits, write "RURAL")
(d) Street No. 1 (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24
year 1943 hour 7 minute 45 P. M.
21. I hereby certify that I attended the deceased from May 13
1943, to May 24, 1943,
that I last saw him alive on May 24, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia Duration 10 da.
Due to Cardiac decompensation
Due to _____

Other conditions None
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy Hypostatic pneumonia
Cardiac degeneration

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?
(Specify type of place) (e) Means of injury _____

23. Signature Geo. M. Butler (M. D. or other)
Address St. Joseph Mo. Date signed 5/24/43

3. (a) PRINT FULL NAME C. M. (MAX) CASTOR

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 2

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

7. Birth date of deceased unknown (Month) (Day) (Year)

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

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name George M. Castor

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

14. Maiden name Wester

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

16. (a) Informant Person at State Hospital #2

(b) Address St. Joseph, Missouri

17. (a) _____ (b) Date thereof May 26-43
(Burial, cremation, or removal) (Monthly) (Day) (Year)

(c) Place: burial or cremation Winters, Mo.

18. (a) Signature of funeral director H. F. Poyser

(b) Address Winters, Mo.

19. (a) 5-26-43 (b) Rose Herzog
(Data received local registrar) (Registrar's signature)

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.....

.....
working under my personal supervision.

my self

....., Registered Apprentice No.

Signed.....

H. F. Carver

Licensed Embalmer No. *1804*

P. O. Address *Piedmont 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.

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:
(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)

3. (a) PRINT FULL NAME C.M. (Max) Caster
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced in
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased unk (Month) (Day) (Year)

8. AGE: Years 21 Months _____ Days _____ If less than one day _____ min.

9. Birthplace (City, town, or county) mo. (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 _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 May day 24
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive pneumo-
bronchial
Due to cardiac decompensation

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: 107
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 _____

23. Signature Ed Tucker M.D. (M.D. or other)

Address St Joseph mo Date signed _____

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

SUPPLEMENTAL

20838