

1-4-41  
5-17-39  
X26390

FILED JUN 29 1943 42  
Registration District No. \_\_\_\_\_

Primary Registration District No. **1001 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 **State Hosp # 2 2**  
(If not in hospital or institution, write street number or location) **6 mos**  
(d) Length of stay: In hospital or institution **6 mos** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cassell**  
(c) City or town **Hackinda** (If outside city or town limits, write "RURAL")  
(d) Street No. **R 7. Q #3** (If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **William Isaac Tatham**

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

4. Sex **MO** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **3. 3.** 6. (c) Age of husband or wife if alive **3.** years  
7. Birth date of deceased **5 16 64** (Month) (Day) (Year)

8. AGE: Years **79** Months **1** Days **5** If less than one day hr. min.

9. Birthplace **Carroll Co. Mo 0** (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **✓**  
12. Name **Wm Tatham**  
13. Birthplace **Mo 0** (City, town, or county) (State or foreign country)  
14. Maiden name **Nancy Barton**  
15. Birthplace **Mo 0** (City, town, or county) (State or foreign country)

16. (a) Informant **Records State Hospital**  
(b) Address **St Joseph, Missouri**

17. (a) **Removal** (b) Date thereof **June 19, 43** (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation **Carrollton, Missouri**

18. (a) Signature of funeral director **Herman H. Bidupadew**  
(b) Address **1802 Union, St. Joseph, Mo.**

19. (a) **6-19-43** (b) **Rose Herzog** (Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **18** year **1943** hour **2** minute **30** A.M.

21. I hereby certify that I attended the deceased from **June 4**, 1943, to **June 17**, 1943  
that I last saw him alive on **June 17**, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic lobar pneumonia both lungs** Duration **3 days**

Due to **Fracture of pelvis & femur** 2 weeks

Other conditions (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) (2) Means of injury **0**

23. Signature **E H Magee** (M. D. or other) **MA**  
Address **St Joseph, Mo** Date signed **6-19-43**

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

12:3

**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..... *John H. Hurley*.....  
Licensed Embalmer No. *4050*.....  
P. O. Address..... *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.**

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 Wm Isaac Tatham

(b) If veteran, name war \_\_\_\_\_

(c) Social Security No. \_\_\_\_\_

4. Sex M | 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: May 16 1866  
(Month) (Day) (Year)

8. AGE: Years 79 | Months 1 | Days 1  
If less than one day \_\_\_\_\_ min.

9. Birthplace MO  
(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 \_\_\_\_\_

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)

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 July year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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: hypostatic labor pneumonia both lungs

Due to: Fracture of pelvis & femur

Due to: a fall on the floor on 6-4-42

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Fell on floor of two wards 1060

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 6-4-42 by a fall

(c) Where did injury occur? State Hosp #2  
(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 E H Magee \_\_\_\_\_ (M.D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

