

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27765

REG SEP 11 1943 35-42  
Registration District No. 42

Primary Registration District No. 1001 1000

Registrar's No. 971

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)  
(d) Length of stay: In hospital or institution 10 yrs  
(Specify whether years, months or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry  
(c) City or town Albany Mo  
(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 Milton Lego  
3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Single  
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 not known 75? Months - Days - If less than one day hr. min.

9. Birthplace Mo - 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Labourer

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Not known  
13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Henry C. Clark

(b) Address Albany Mo

17. (a) Burial (b) Date thereof 8/23/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph #2

18. (a) Signature of funeral director John C. Clark

(b) Address 605 4 Bryan St. St. Joseph, Mo

19. (a) 8/23/43 (b) Abel Clark  
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 21  
year 1943 hour 4:05 minute PM

21. I hereby certify that I attended the deceased from August 9, 1943 to August 23, 1943  
that I last saw him alive on August 23, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia

Due to uremia Priming

Due to \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
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 R. B. Smeary (M. D. or other) MD

Address State Hosp #2 Date signed 8-24-43

**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.....  
*Body was not embalmed*..... Registered Apprentice No.....  
working under my personal supervision.

Signed..... *John E. Kemp*.....  
Licensed Embalmer No. *3986*  
P. O. Address *St Joseph*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 447

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County DuCheneau  
(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 #2  
(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 Milton Lego

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 \_\_\_\_\_

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

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 75 Months \_\_\_\_\_ 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 \_\_\_\_\_  
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)

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 Aug Day 21 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 \_\_\_\_\_

Due to Chronic Nephritis  
Chemical Poisoning

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) \_\_\_\_\_  
(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? \_\_\_\_\_

23. Signature R. B. Sweany (M. D. or other) MD  
Address St. Joseph, Mo Date signed 8-24-43  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

277165