

LED SEP 24 1943

Registration District No. 1000

Primary Registration District No. 1000

Registrar's No. 1021

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: Base Hospital, Rosecrans Field
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 1/2 Days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Ohio (b) County 999
 (c) City or town Hopedale 33
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country 2

3. (a) PRINT FULL NAME Pfc William Raber
 3. (b) If veteran, # 35377811 name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month September day 8th
 year 1943 hour 4 minute P M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from September 6 1943 to September 8 1943
 that I last saw him alive on September 8 1943
 and that death occurred on the date and hour stated above.

7. Birth date of deceased: Oct 3 1921
 (Month) (Day) (Year)

8. AGE: Years 22 Months 11 Days 5
 If less than one day _____ hr. _____ min.

Immediate cause of death:
 1. Cerebral Hemorrhage Duration 2 Days
 2. Punctured lung "
 Due to: Ruptured Spleen "
 4. Fractures Rib & Femur "
 Due to: Multiple Cont. & lacer.
 6. RT. Lobar Pneumonia

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Unknown

11. Industry or business:

12. Name Unknown

13. Birthplace Unknown (City, town, or county) (State or foreign country) 9

14. Maiden name _____

15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

Major findings: Of operations 173-8

Of autopsy as above 34

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Post Records
 (b) Address Rosecrans Field

17. (a) Removal Removal (b) Date thereof 9-9-43
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Hopedale, Ohio

18. (a) Signature of funeral director Fleeman & Son Inc.
 (b) Address St Joseph, Mo.

19. (a) 9/9/43 (b) Rose Hegroff
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) Accident 136
 (b) Date of occurrence Sept 5th, 1943
 (c) Where did injury occur? Wathena, Doniphan, Kans.
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Plane Crash on Farm
 While at work? Yes (Specify type of place) Plane Crash
 Means of injury _____

23. Signature Gerald J. Clark (M.D. or other) 9-9-43
 Address St Joseph, Mo. Date signed 9-9-43

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

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.

Signed.....

Robert H. Gable

Registered Apprentice No.

Licensed Embalmer No.

3308

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.