

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

130712C  
Do not use this space.

FILED DEC 6 1943

1. PLACE OF DEATH

(a) County Buchanan <sup>999 14</sup> Registration District No. 42  
(b) Township H. Joseph Primary Registration District No. 1000 Registered No. 1288  
(c) City H. Joseph (d) Street No. Missouri Methodist Hospital St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 1401 Sparks, Kans. St.  Sparks, Kansas  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) not known

7. AGE YEARS MONTHS DAYS If LESS than 1 day hrs. or min.  
About 83 years

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) Jan 1933 11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

13. NAME unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT Hospital Records (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL Removal  
PLACE Sparks, Mo. DATE 11-9 1943

19. FUNERAL DIRECTOR (NAME) E. F. Karr  
(ADDRESS) Tracy - Kans.

20. FILED 11-1 1943 Rob Heigoy  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-8 1943

22. I HEREBY CERTIFY, That I attended deceased from 2-20 1943, to 11-8 1943

I last saw him alive on 11-8 1943. Death is said

to have occurred on the date stated above, at 10:25 pm.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage Date of onset

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Other contributory causes of importance:

arteriosclerosis and Hypertension

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Paul Forgyver, M. D.

(Address) 8th & Tenth, St. Joseph, MO.

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**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..... *E. F. Karr* .....

Licensed Embalmer No. *2586* .....

P. O. Address *Troy, Kansas* .....

**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, above space should be left blank.**