

FILED MAR 15 1944

Registration District No. *1000*

Primary Registration District No. *1000*

Registrar's No. **227**

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

1. PLACE OF DEATH:

(a) County *Buchanan*
(b) City or town *St. Joseph Mo*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution *912 So. 16th St. Joseph Mo*
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community *One year* (Specify whether years, months or days) *Feb*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Buchanan*
(c) City or town *St. Joseph*
(If outside city or town limits, write "RURAL")
(d) Street No. *912 So. 16th St*
(If rural, give location)
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME *Thomas O. McAfee*

3. (b) If veteran, name war *X* 3. (c) Social Security No. *1235*

4. Sex *Male* 5. Color or race *white* 6. (a) Single, widowed, married, divorced, *widowed*
6. (b) Name of husband or wife *Lou McAfee* 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased *2 1854*
(Month) (Day) (Year)

8. AGE: Years *90* Months _____ Days *2* If less than one day _____ hr. _____ min.

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

10. Usual occupation *farmer*

11. Industry or business _____

12. Name *Chas. McAfee*

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

14. Maiden name *Unknown*

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

16. (a) Informant *Mrs. Myrtle Scholty*

(b) Address *912 So. 16th St. Joseph Mo*

17. (a) *Burial* (b) Date thereof *2 15 1944*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Torbes Mo*

18. (a) Signature of funeral director *J. Fred Terhune*

(b) Address *Savannah Mo*

19. (a) *2-15-44* (b) *Rose Herzog*
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Feb* day *14*
year *1944* hour *8* minute *10 P.M.*

21. I hereby certify that I attended the deceased from *Feb 13*
_____, 19*44* to *Feb 14*, 19*44*,
that I last saw him alive on *Feb. 13*, 19*44*,
and that death occurred on the date and hour stated above.

Immediate cause of death *Coronary Embolism* Duration *36 hrs*
Due to *Arterio Sclerosis* *10 yrs*

Due to _____
Other conditions *none*
(Include pregnancy within 3 months of death)

Major findings: Of operations *no* Of autopsy *no*
PHYSICIAN *gfa*
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) (c) Means of injury *0*

23. Signature *Gordon Deight MD* (M. D. or other) *MD*
Address *845 S. 19th St. Joseph* Date signed *2/15/44*

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.....

A. Fred Terhune

Registered Apprentice No.

working under my personal supervision.

Signed.....

A. Fred Terhune

Licensed Embalmer No. *1279*

P. O. Address *Savannah*

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.