

No. 2
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17-39
X36671

FILED APR 10 1944

Registration District No. **42**

Primary Registration District No. **1034**

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

1. PLACE OF DEATH:
 (a) County **Buchanan**
 (b) City or town **"Rural" Washington**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
County Infirmary
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **2 1/2 years**
(Specify whether life years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Buchanan**
 (c) City or town **"Rural" Washington**
(If outside city or town limits, write "RURAL")
 (d) Street No. **County Infirmary**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **ROBERT H. PILCHER**
 3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**
 4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **divorced**
 6. (b) Name of husband or wife **Goldie Pilcher** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Jan., 26 1880**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **March** day **15th** year **1944** hour **2** minute **35 P.M.**
 21. I hereby certify that I attended the deceased from **March 4th 1944** to **March 15th 1944** that I last saw him alive on **March 15th 1944** and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
64 1 19 hr. min.

Immediate cause of death **Cerebral Hemorrhage 1 hour**
 Due to _____
 Due to _____

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

Other conditions **arterio-sclerosis 5 years**
(Include pregnancy within 3 months of death)

10. Usual occupation **retired hotel manager**

11. Industry or business **Pilcher Hotel**

Major findings: **none**
 Of operations **none**
 Of autopsy **none**
PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name **Hugh Pilcher**
 13. Birthplace **unknown unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Josephine Swalls**

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

16. (a) Informant **Mr. A. R. White**

(b) Address **St. Joseph, Mo 2141 St. Jo. Ave**

17. (a) **burial** (b) Date thereof **3/18/44**
(City, town, or county) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Auburn**

18. (a) Signature of funeral director **Robert H. Bowman**

(b) Address **319 South 10th Street**

19. (a) **3/16/44** (b) **Rose Herzog**
(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) _____
 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 **John H. ...** (M. D. ...)
 Address **...** Date signed **3.16.44**

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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

Elmer Thomas

Licensed Embalmer No.

2640

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.