

FILED JUL 7 1944

Registration District No. 472

Primary Registration District No. 1000

Registrar's No. 683

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 St Joseph's Hosp 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 Da (Specify whether
In this community 10 Da years, months or days)

3. (a) PRINT FULL NAME Wilford Enyart
3. (b) If veteran, name war. — 3. (c) Social Security No. —

4. Sex Male⁰ 5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Minnie
6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased Sept 22 1867 (Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 7 If less than one day hr. min.

9. Birthplace Gentry Co. Mo 0 (City, town, or county) (State or foreign county)
10. Usual occupation Retired Farmer

11. Industry or business
12. Name James T. Enyart
13. Birthplace Gentry Mo 4 (City, town, or county) (State or foreign county)
14. Maiden name Unknown
15. Birthplace Gentry Mo 9 (City, town, or county) (State or foreign county)

16. (a) Informant Minnie Enyart
(b) Address MC Fall Mo
17. (a) Removal (b) Date thereof 6-30-44 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Patton's burg Mo

18. (a) Signature of funeral director Fleeman & Son Inc
(b) Address St Joseph Mo
19. (a) 6/30/44 (b) Helen Pichler (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town MC Fall 38 (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 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29 year 1944 hour 6 minute P.M.
21. I hereby certify that I attended the deceased from 6-13, 1944, to June 29, 1944, that I last saw him alive on 6-29, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Bronchial
Duration 2 wks

Due to 93d
Due to

Other conditions Art. Scler. Heart Disease (Include pregnancy within 3 months of death)
Nephrotrophy prostate, Cyst of Kidney

Major findings: Of operations Bronchopneumonia Heart art scler Of autopsy Cyst of Kidney
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? (Specify type of place)

While at work? (e) Means of injury
23. Signature Dr. D. J. Jensen (M. D. or other) no
Address Safford Mo Date signed 6-30-44

MOTHER FATHER

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FEB 27 1948

FEB 28 1948

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 _____

Robert H. Gable

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.