

FILED JUL 20 1944

Registration District No. **2**

Primary Registration District No. **1000**

Registrar's No. **722**

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

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: **State Hospital No 2**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. **10 yrs 11 mo 10 da**
(Specify whether years, months or days)
 In this community **yes**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Jackson**
 (c) City or town **Kansas City**
(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 _____

3. (a) PRINT FULL NAME **Roy M Dyer**
3. (b) If veteran, name war **WW**
3. (c) Social Security No. **none**

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

7. Birth date of deceased: **not given**
(Month) (Day) (Year)

8. AGE: Years **58** Months **?** Days **?**
 If less than one day _____ hr. _____ min.

9. Birthplace **Bales Co Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Truck driver**

11. Industry or business _____
12. Name **William March**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Bridget O'Riley**
15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Hospital**
(b) Address **St Joseph MO**

17. (a) (b) Date thereof **7-8-44**
(Month) (Day) (Year)
(c) Place: burial or cremation **not done**

18. (a) Signature of funeral director **Oliver Funeral Home**
(b) Address **St Joseph Mo**
19. (a) (b) (Registrar's signature) **Walter C. Baker**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **6th**
 year **1944** hour **12** minute **30A** M.
21. I hereby certify that I attended the deceased from **an**
July 6, 19**44** to _____, 19____
 that I have seen him _____ alive on _____, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Acute Coronary Thrombosis 1 day**
Due to: **Chronic Myocarditis, 10 yrs.**

Due to: **Man died suddenly at the state hospital.**
Other conditions: **after a scuffle with another patient, some minor scratches on his face of minor importance.**
Of operations: _____
Of autopsy: **no importance.**
no evidence of serious injury.

Duration
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 **7-8-44**
(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? _____

23. Signature **H F Munday** **Coroner**
(Specify type of place) (e) Means of injury
Address **464 So 3rd St** **Date signed** **7/6/44**

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STATEMENT BY LICENSED EMBALMER

not

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 *John Roy Plawitz*

Licensed Embalmer No. *2435*

P. O. Address *St. Joseph*

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.