S. No. 2
I—9-4-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 4 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

33688

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1081

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 28 yrs 0 M 25 da (Specify whether
In this community 2 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Caldwell
(c) City or town Kingston
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No D (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME WALTER ESTEB

3. (b) If veteran, name war ✓ 3. (c) Social Security No. None

4. Sex M O 5. Color or race W 6. (a) Single, widowed, married, divorced Single O

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive years

7. Birth date of deceased December 12 1880 (Month) (Day) (Year)

8. AGE: Years 63 Months 10 Days 17 If less than one day hr. min.

9. Birthplace O Mo (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

FATHER
12. Name not given
13. Birthplace Not given O (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name not given
15. Birthplace not given O (City, town, or county) (State or foreign country)

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

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct 30 1944 (Month) (Day) (Year)
(c) Place: burial or cremation State Hospital Cemetery

18. (a) Signature of funeral director Mrs. E. R. Sidenfaden
(b) Address 602 So. 60th Street

19. (a) 10-30-44 (Date received local registrar) (b) Helen I Pickle (Registrar's signature)

1311

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28 year 1944 hour 10-30 minute A M.

21. I hereby certify that I attended the deceased from Died in Chair, 19 , to Sudden, 19 ; that I last saw ~~him~~ alive on Oct 28, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Dilation

Due to Cardiac Hypertrophy and Nephritis

Due to

Other conditions mental deficient without Psychosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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
(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 O

23. Signature C E Salyer (M. D. ~~or other~~)
Address St Joseph Mo, Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. S. No. 2B
0M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1081

SUPPLEMENTARY

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:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Walter Esteb

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec (Month) 12 (Day) 1880 (Year)

8. AGE: Years 63 Months 10 Days 17 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Dilation

Due to Cardiac Hypertrophy and nephritis

Due to Chronic

Other conditions mental deficient without Psychosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION

13/15

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

(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 (M. D. or other)

Address [illegible] MA. Date signed

33688