

FILED NOV 4 1944  
42

Registration District No. 42

Primary Registration District No. 1205

Registrar's No. 1083

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:  
2126 South 6th St  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no  
30 years (Specify whether years, months or days)

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. 2126 South 6th St  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Grover A. Stallsworth

3. (b) If veteran, name war no

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 29  
year 1944 hour 12, minute 25 P.M.

21. I hereby certify that I attended the deceased from Sept 17, 1944 to Oct 28, 1944  
that I last saw him alive on Oct 28, 1944  
and that death occurred on the date and hour stated above.

4. Sex Male ( ) 5. Color or race White  
6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband or wife Elizabeth  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased July 22, 1888  
(Month) (Day) (Year)

Immediate cause of death: Cancer of tongue with metastases to the throat  
Due to starvation 620

|         |       |        |      |                      |
|---------|-------|--------|------|----------------------|
| 8. AGE: | Years | Months | Days | If less than one day |
|         | 56    | 3      | 7    | hr. min.             |

Due to

Other conditions (Include pregnancy within 3 months of death)

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

10. Usual occupation Laborer

PHYSICIAN

Major findings: Of operations 45  
Of autopsy

Underline the cause to which death should be charged statistically.

11. Industry or business unknown

12. Name unknown

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

14. Maiden name unknown

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

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 places in public place? (Specify type of place)

16. (a) Informant Mrs Elizabeth Stallsworth  
(b) Address 2126 South 6th St, St. Joseph

17. (a) Burial (b) Date thereof 11-1-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Auburn Cemetery

23. Signature of physician: Dr. Charles B. Werner  
Address: 221 Kirkpatrick Rd, St. Joseph, Mo. 10-31-1944

18. (a) Signature of funeral director Barry Funeral Home  
(b) Address 224 South 10th St, St. Joseph, Mo.

19. (a) 11-1-44 (b) Neal T. Becke  
(Date received local registrar) (Registrar's signature)

1377 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

**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

*Mollie E. Sidenfaden Fro*

Licensed Embalmer No.

*4235*

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.**