

FILED DEC 16 1944
Registration District No. 2

Primary Registration District No. 1000

Registrar's No. 1236

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 Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether
In this community 30 years
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. 1131 Edmond St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 11

3. (a) PRINT FULL NAME Joseph Karl Marical

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race white 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. unknown
(Month) (Day) (Year)

8. AGE: Years 61 Months - Days - If less than one day hr. min.

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

10. Usual occupation Fired furnaces

11. Industry or business.

MOTHER FATHER { 12. Name unknown 9
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown 9
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Edward Marical

(b) Address Axtell, Kansas

17. (a) Burial (b) Date thereof. 12-11-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Barry Funeral Home

(b) Address 224 South 10th St, St. Joseph

19. (a) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7
year 1944 hour Seven minute 06 A.M.

21. I hereby certify that I attended the deceased from December 4 1944 to December 7 1944
that I last saw him alive on December 6 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to trauma of undetermined origin 3 days
Due to

Other conditions 3h
(Include pregnancy within 3 months of death)

Major findings: Of operations Of autopsy

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?

While at work? (Specify type of place) (e) Means of injury 0
23. Signature W. M. J. [unclear] (M. D. or other)
Address Social Welfare Board Date signed 12-8-44

1871

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

12
43
39
37823

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. Lidenfaden 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1236
Registrar's No. 1236

Registration District No. 42 Primary Registration District No. 1000

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)

3. (a) PRINT FULL NAME Joseph K. Marcial
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 8
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased unk. (Month) (Day) (Year)

8. AGE: Years 61 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

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

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

19. (a) 1-31-45 (b) Robert Pickle
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14 year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, that I last saw him/her alive on _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

1944
S-40697