. S. No. 2
OM—8-43
v. 5-17-39
I X37823

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

9088

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 11 1945

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 367

1. PLACE OF DEATH:

(a) County Buch anan
(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hospital 0 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 hours (Specify whether
In this community 40 years years, months or days)

2. USUAL RESIDENCE OF DECEASED: 11

(a) State Missouri (b) County Buchanan 1
(c) City or town St. Joseph 7 (If outside city or town limits, write "RURAL")
(d) Street No. 2018 Francis St (If rural, give location)
(e) Citizen of foreign country? no 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Thomas Gartland
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex Male 0
5. Color or race white
6. (a) Single, widowed, married, divorced single 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased December 25, 1876 (Month) (Day) (Year)

8. AGE: Years 68 Months 3 Days 9 If less than one day hr. min.

9. Birthplace (City, town, or county) Illinois (State or foreign country)
10. Usual occupation Flagman
11. Industry or business Burlington Ry
FATHER
12. Name unknown
13. Birthplace (City, town, or county) unknown (State or foreign country) 9
MOTHER
14. Maiden name unknown
15. Birthplace (City, town, or county) unknown (State or foreign country) 9
16. (a) Informant Social Security Records
(b) Address Patee Hall
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Olivet Cemetery
18. (a) Signature of funeral director Barry Funeral Home
(b) Address 224 Southb10th St, St. Joseph, Mo.
19. (a) 4-9-45 (Date received local registrar) (b) Helen J. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4 year 1945 hour 8 minute 30 P M.

21. I hereby certify that I attended the deceased from 3/9/44, 19 , to April 4th, 1945 that I last saw him alive on April 4th, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	1 da
Due to chronic myocarditis	6 mo
Due to	
Other conditions Epidermoid CA--left eye treated at CA Hospital; Columbia	1 yr.

(Include pregnancy within 3 months of death)

Major findings: Of operations Missouri; 3/44
Of autopsy none 55

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) none
(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 0

23. Signature W. M. Toothaker M.D. (M. D. or other)
Address Social Welfare Board Date signed 4/6/45

1511

(Licensed Embalmer's Statement on Reverse Side)

APR 25 1945

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 Fox

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.