

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12946

State File No.

FILED APR 21 1945

Registrar's No. 403

Registration District No. 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:
Mo. Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 24 days
(Specify whether
In this community 24 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. 305 So. 31st
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Carl J. White
3. (b) If veteran, name war none
3. (c) Social Security No. 445-10-5479

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 5
year 1945 hour 1 minute 10P M.

4. Sex male () 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Ruth M. White
6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased March 16 1885
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
Apr 1944 to Apr 5 1945
that I last saw him alive on Apr 5 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Malignant disease
Duration 1 yr.

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-------|--------|------|----------------------|
| | 60 | 0 | 19 | hr. min. |

Due to
Due to

9. Birthplace: D. Cass Iowa
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation mens clothing
11. Industry or business Cliff Geis Haberdasher

Major findings: Of operations

MOTHER FATHER
12. Name Lewis White
13. Birthplace unknown Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Ida Boots
15. Birthplace unknown unknown
(City, town, or county) (State or foreign country)

Of autopsy same 4/4/45
PHYSICIAN Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. C.J. White
(b) Address 305 So. 31st
17. (a) burial (b) Date thereof 4/9/45
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:

(c) Place: burial or cremation Memorial Park
18. (a) Signature of funeral director Nestor Betale & Bowman
(b) Address 319 So. 10th
19. (a) 4/9/45 (b) [Signature] (Registrar's signature)

(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 [Signature] (M. D. or other) MD
Address St Joseph MO Date signed 4-7-45

1377 (Licensed Embalmer's Statement on Reverse Side)

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

JUN 16 1945

Dr. J. N. Farrow
Herk. Bldg.

JUN 16 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 Herald I Wade
Licensed Embalmer No. 4172
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.