

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16429**
Registrar's No. **571**

FILED JUN 2 1945
Registration District No. **72**

Primary Registration District No. **1000**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St Joseph**
(c) Name of hospital or institution: **State Hospital #2**
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 mo 15 da**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

John Zachary

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex **M** 5. Color or race **N**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive **12** years
7. Birth date of deceased **Mich 12 1865**
(Month) (Day) (Year)

8. AGE: Years **80** Months **2** Days **16**
If less than one day hr. min.

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

10. Usual occupation **Drum Major**

11. Industry or business

12. Name **Born Zachary**
13. Birthplace **Anderson Co Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Nancy Pascale**
15. Birthplace **Anderson Co Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **John Nelson**
(b) Address **Mound City Mo**
17. (a) **Burial** (b) Date thereof **5-31-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mound City Mo**

18. (a) Signature of funeral director **W H Brumfield**
(b) Address **Mound City Mo**
19. (a) **5-29-45** (b) **John L. Pickle**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **28**
year **1945** hour **3** minute **0** M.
21. I hereby certify that I attended the deceased from **May 25**, 1945, to **May 28**, 1945,
that I last saw him alive on **May 28**, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death **Branchial pneumonia** Duration **3 days**

Due to
Due to

Other conditions
(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) (c) Means of injury

23. Signature **L S Stuck** (M. D. or other)
Address **State Hosp #2** Date signed **5/29/45**

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

J. H. Crawford

Licensed Embalmer No.

1824

P. O. Address

Mound City 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.