

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23224**
Registrar's No. **2781**

FILED JUL 17 1945
Registration District No. **149**

Primary Registration District No. **1002**

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

18
3
8

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Tamias City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4100 E. Front 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community 57 year
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Tamias City **3**
(If outside city or town limits, write "RURAL")

(d) Street No. 4100 East Front **8**
(If rural, give location)

(e) Citizen of foreign country? no **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME PETE. SOETAERT

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30
year 1945 hour 7 am minute _____ M.

21. I hereby certify that I attended the deceased from 1940, 19____, to June 30, 1945
that I last saw him alive on June 20, 1945
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Wht

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Julina Soetaert 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Aug 25 1897
(Month) (Day) (Year)

Immediate cause of death Cornary Aneurism
Branchial Aneurism

Duration _____

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

<u>57</u>	<u>10</u>	<u>5</u>	_____ hr. _____ min.
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Due to _____

Due to _____

9. Birthplace Belgium **4**
(City, town, or county) (State or foreign country)

10. Usual occupation Gardner

Other conditions none
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business Truck, Gardener

12. Name Fred Soetaert **4**

13. Birthplace Belgium **4**
(City, town, or county) (State or foreign country)

14. Maiden name Mary Brant **4**

15. Birthplace Belgium **4**
(City, town, or county) (State or foreign country)

Major findings: none

Of operations _____

Of autopsy no

16. (a) Informant Julina Soetaert, wife

(b) Address 4100 E. Front

17. (a) Burial (b) Date thereof July 3, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Mary

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? _____

18. (a) Signature of funeral director Walter

(b) Address 7657 Judy Ave.

19. (a) 7-2-45 (b) Margaret Holmes
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature J. H. Dennis (M. D. or _____)

Address Kearney City Mo Date signed 7/30/45

(Licensed Embalmer's Statement on Reverse Side)

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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,

 Registered Apprentice No.
working under my personal supervision.

Signed:
Quinn L. Taylor
Licensed Embalmer No. *74225*

P. O. Address: *Indep. 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.