

S. No. 2
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v. 5-17-39
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26836

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED SEP 12 1945
Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 949

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 1 day
(Specify whether years, months or days)

In this community 3 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town Faucett
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Joseph Clouser

3. (b) If veteran, name war none

3. (c) Social Security No. none

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 March 1859
(Month) (Day) (Year)

8. AGE: Years 86 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace Buchanan County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation retired farmer

11. Industry or business.....

MOTHER FATHER { 12. Name William F. Clouser

13. Birthplace unknown Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Mariam Adeline Russell

15. Birthplace unknown N. Car.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Susan E. Murphy

(b) Address Weston, Mo.

17. (a) burial (b) Date thereof 9/6/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Turner Cemetery

18. (a) Signature of funeral director Thos. Belle & Bowman

(b) Address 319 South 10th

19. (a) 9/6/45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 4th
year 1945 hour 6 minute 15 P. M.

21. I hereby certify that I attended the deceased from Sept 3 1945 to Sept 4 1945
that I last saw him alive on Sept 4 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: uraemia Duration 2 days

Due to Chronic Pyelonephritis 2

Due to Practile Hypertrophy 2

Other conditions: [blank]
(Include pregnancy within 3 months of death)

Major findings: none 130

Of operations none

Of autopsy none

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? [blank] (Specify type of place) (c) Means of injury.....

23. Signature [Signature] (M. D. or other) 0

Address St. Joseph, Mo. Date signed 9/5/45

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

1428

(Licensed Embalmer's Statement on Reverse Side)

Mr. J. J. Banaback
825 1/2 7th St.

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

Gerald I Wacke

Licensed Embalmer No.

4172

P. O. Address

St. Joseph

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.