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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

26851

State File No.

FILED SEP 4 1945

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 875

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

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 Hosp. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3 (If outside city or town limits, write "RURAL")
(d) Street No. 2825 Indiana Ave 8 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME Daniel Engeland
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Male 0
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 Aug (Month) 29 (Day) 1934 (Year)

8. AGE: Years 10 Months 11 Days 14 If less than one day hr. min.

9. Birthplace St Joseph (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation At Home
11. Industry or business
FATHER
12. Name Silas Engeland
13. Birthplace Daviess Co. (City, town, or county) Mo 0 (State or foreign country)
MOTHER
14. Maiden name Gergie
15. Birthplace (City, town, or county) Mo. 0 (State or foreign country)
16. (a) Informant Mrs Silas Engeland
(b) Address K. C. Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-13-45 (Month) (Day) (Year)
(c) Place: burial or cremation Pattonsburg Mo
18. (a) Signature of funeral director Fleeman & Son Inc
(b) Address St Joseph Mo.
19. (a) 8-13-45 (Date received local registrar) (b) Helen I Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 12 year 1945 hour 5 minute 20 P.M.
21. I hereby certify that I attended the deceased from 8-10, 1945, to 8-12, 1945 that I last saw him alive on 8-12, 1945; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Cerebral Edema | 2 days |
| Due to Fracture Skull | 2 days |
| Due to | |
| Other conditions 0 (Include pregnancy within 3 months of death) | |
| Major findings: Of operations 0 | |
| Of autopsy 0 | |

PHYSICIAN
Underline the cause to which death should be charged statistically.

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22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 8-10-45 38
(c) Where did injury occur? King City (City or town) Gentry (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place (Specify type of place)
While at work? No (e) Means of injury Jumped from Truck to street
23. Signature J. H. Reese M.D. (M. D. or other)
Address St Joseph Mo Date signed 8.12.45

1377 (Licensed Embalmer's Statement on Reverse Side)

## 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 Robert K. Gaple

Licensed Embalmer No. 3308

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.**