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I-9-4-41  
7-5-17-39  
X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

26863

State File No. ....

Registrar's No. **836**

**FILED** AUG 20 1945

Registration District No. **72**

Primary Registration District No. **1600**

**1. PLACE OF DEATH:**

(a) County Buchanan

(b) City or town St. Joseph Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp # 22  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 53, 7 mo, 19 d  
(Specify whether years, months or days)

In this community unk

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Platte **11**

(c) City or town Platte City **1**  
(If outside city or town limits, write "RURAL")

(d) Street No. 7  
(If rural, give location)

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

**3. (a) PRINT FULL NAME** Celia Geyer

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased unk  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 8, 15 day, 1945 year, 4:02 hour, 10 minute, AM M.

21. I hereby certify that I attended the deceased from 7:23 to 8:11 1945 that I last saw her alive on 8-1-1945 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Peritonitis

Due to Coronal Artery Sclerosis

Due to General

Other conditions unk  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

8. AGE: Years 79 Months unk Days unk If less than one day unk hr. unk min. unk

9. Birthplace unk unk  
(City, town, or county) (State or foreign country)

10. Usual occupation unk

11. Industry or business unk

MOTHER FATHER

12. Name unk

13. Birthplace unk 9  
(City, town, or county) (State or foreign country)

14. Maiden name unk

15. Birthplace unk 9  
(City, town, or county) (State or foreign country)

16. (a) Informant State Hospital Records

(b) Address St. Joseph Mo

17. (a) Burial (b) Date thereof 8-3-45  
(Burial, cremation, or exposure) (Month) (Day) (Year)

(c) Place: burial or cremation State Hospital Cemetery

18. (a) Signature of funeral director unk

(b) Address 602 S 10th St

19. (a) 8-3-45 (b) John J. Peble  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations unk

Of autopsy unk

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? \_\_\_\_\_  
(Specify type of place)

While at work? 0 (g) Means of injury 0

23. Signature P. J. ... (M. D. or other) \_\_\_\_\_

Address unk Date signed 8.11.45

1377

(Licensed Embalmer's Statement on Reverse Side)

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

STATEMENT BY LICENSED EMBALMER

*Did not embalm*

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

*Mollie E. Sidenhaden Fr*

Licensed Embalmer No.

*4235*

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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept  
Registrar's No. 836

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Celia Guyer  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive unknown  
7. Birth date of deceased 10-12  
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER, FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Robert J. (Trickle)  
(Date received local registrar) (Registrar's signature)

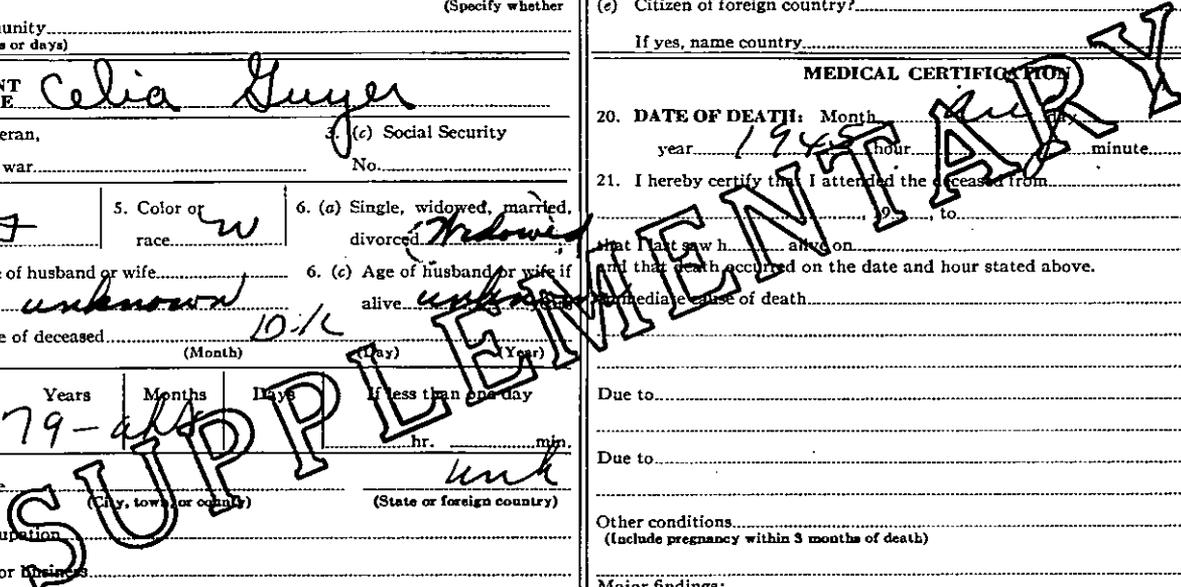
2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.  
Duration \_\_\_\_\_  
Immediate cause of death \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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



5-26863