

S. No. 2
M-843
v. 5-17-39
I X37823

27158

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 13 1945

Registration District No. 74

Primary Registration District No. 4136

Registrar's No. 33-40

1. PLACE OF DEATH:

(a) County Clinton

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

(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 yrs; (Specify whether years, months or days)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Clinton 25

(c) City or town Plattsburg ?
(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 A. F. FULLER

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 widowed

6. (b) Name of husband or wife Margaret

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 1856
(Month) (Day) (Year)

8. AGE: Years 89 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business self

12. Name Unknown

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

14. Maiden name Unknown

15. Birthplace Unknown 0
(City, town, or county) (State or foreign country)

16. (a) Informant E. N. Huriman

(b) Address St. Joseph, Mo.

17. (a) Burial (b) Date thereof Aug. 6, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Rupp Funeral Home

(b) Address 6054 Pryor, St. Joseph Mo.

19. (a) 8-6-45 (b) Mrs A C Hartell
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 3 year 1945 hour 10 minute 02 AM

21. I hereby certify that I attended the deceased from April 10, 1945 to Aug 3, 1945 that I last saw him alive on July 7, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death 77 years old

Due to Hypertension

Due to _____

Duration 30da
1yr

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none 939

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? _____

(Specify type of place) While at work? _____ Means of injury _____

23. Signature W B Shelding MD (M. D. or other) MD
Address Plattsburg Mo Date Aug 8-45

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

5
0
3
0

Mrs. E. Hartell

4 2 1 1 7 3 1

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 *Mollie E. Sidenfaden*
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.