. S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30123

FILED OCT 4 1945

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1033

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. Meth. Hosp. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 40 Min. (Specify whether
In this community 56 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11
(c) City or town St Joseph 1 (If outside city or town limits, write "RURAL")
(d) Street No. 402 No 7th 7 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Ralph E. Costigan
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Sarah
6. (c) Age of husband or wife if alive Not Stated years
7. Birth date of deceased Nov (Month) 24 (Day) 1874 (Year)

8. AGE: Years 70 Months 9 Days 22 If less than one day hr. min.

9. Birthplace Suison (City, town, or county) Calif 1 (State or foreign country)
10. Usual occupation Retired - Realestate
11. Industry or business
FATHER
12. Name Wm Costigan
13. Birthplace unknown 9 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Kathryn Norman
15. Birthplace unknown 9 (City, town, or county) (State or foreign country)
16. (a) Informant Walter Bartlett 1
(b) Address St Joseph Mo
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9-25-45 (Month) (Day) (Year)
(c) Place: burial or cremation K.C. Mo.
18. (a) Signature of funeral director Fleeman & Son Inc
(b) Address St Joseph Mo.
19. (a) 9-27-45 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 16 year 1945 hour 11 minute 50 P M.

21. I hereby certify that I attended the deceased from Sept 16, 1945, to Sept 16, 1945; that I last saw him alive on Sept 16, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Beri Beri - well form General avitaminoses
Due to and other dietary deficiencies
Due to a the result of deceased's unassisted attempts to control Diabetes Mellitus

Other conditions (Include pregnancy within 3 months of death) Blood sugar when first seen 9-16-45

Major findings: Of operations 55 mg per 100 c.c. No acidosis
Of autopsy I saw him in 1935 in Diabetic Coma

Duration

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? (e) Means of injury

23. Signature S. E. Senior (M. D. or other) MD
Address St Joseph, Mo Date signed 9-17-45

1428

(Licensed Embalmer's Statement on Reverse Side)

FEB 3 - 1948

MAR 18 1946

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 L. Yaple

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.