. S. No. 2
DM—8-43
v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 4 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30126

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 991

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: St. Joseph Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days (Specify whether

In this community 45 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph (If outside city or town limits, write "RURAL")

(d) Street No. 3106 Messanie St (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Joseph Dawaliby

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Rose

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased April 3 1880 (Month) (Day) (Year)

8. AGE: Years 65 Months 5 Days 9 If less than one day hr. min.

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

10. Usual occupation operated Fruit Stand

11. Industry or business

FATHER
12. Name Eddie Dawaliby
13. Birthplace Zahlie Syria (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Susie S attlee
15. Birthplace Zahlie Syria (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Rose Dawaliby

(b) Address 3106 Messanie St, St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-45 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olivet Cemetery

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

(b) Address St. Joseph, Mo.

19. (a) 9-21-1945 (Date received local registrar) (b) H J Nestlehuck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12 year 1945 hour 9 minute P. M.

21. I hereby certify that I attended the deceased from March 17, 1945, to Sept 12, 1945; that I last saw him alive on Sept 12, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of rectum (Primary)	6 to 8 months
Due to	
Due to	
Other conditions: Diab. mel. (Include pregnancy within 3 months of death)	?

Major findings:
Of operations
Of autopsy no 46d

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 Frank Hardigan (M. D. or other)

Address 620 Francis Date signed 9/13/45

1428

(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 Mollie E. Siderfaden Fox

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.