. S. No. 2
OM—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

FILED OCT 4 1945

State File No. 30131

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1020

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: 1320½ Penn St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 11 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. 1320½ Penn St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William Thomas Flood
3. (b) If veteran, name war None
3. (c) Social Security No. 491-10-1460
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Orma
6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased December (Month) 29 (Day) 1888 (Year)

8. AGE: Years 56 Months 8 Days 23 If less than one day hr. min.

9. Birthplace Kansas City (City, town, or county) Missouri. (State or foreign country)
10. Usual occupation Machinist
11. Industry or business Western Tablet Co.

FATHER
12. Name Wm. H. Flood
13. Birthplace Unknown (City, town, or county) Canada. (State or foreign country)

MOTHER
14. Maiden name Sarah Kahoe
15. Birthplace Dayton (City, town, or county) Ohio. (State or foreign country)

16. (a) Informant Mrs. Wm. T. Flood
(b) Address 1320½ Penn St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep't. 24, 45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olivet Cemetery
18. (a) Signature of funeral director Herman Wm. Indenfaden
(b) Address 1802 Union St. St. Joseph, Mo.
19. (a) Sep't. 25, 45 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 22 year 1945 hour 7 minute 50 A.M.
21. I hereby certify that I attended the deceased from Sept 19, 1945 to Sept 22, 1945 that I last saw him alive on Sept 21, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis 2 yrs?
Due to First seen by me Jan 1944. Diagnosis
Due to made Time since spent at Mt. Vernon Sanitorium and at home
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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 C. S. Grant (M. D. or other) MD
Address St. Joseph, Mo. Date signed 9-22-45

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~~ Elmer Thomas, Registered Apprentice No. ....., working under my personal supervision.

Signed Elmer Thomas

Licensed Embalmer No. 2640

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.