No. 2
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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 SEP 18 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30753

Registration District No. 155 Primary Registration District No. 5579 Registrar's No. 27

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution: Jasper Co T B Hospital O (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks (Specify whether years, months or days)

In this community ~~Michal~~

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. 201 East Michigan 7 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Michal Halkow

3. (b) If veteran, name war —

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widower 2

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov (Month) 16 (Day) 1864 (Year)

8. AGE: Years 80 Months 8 Days 23 If less than one day hr. min.

9. Birthplace Austria (City, town, or county) 4 (State or foreign country)

10. Usual occupation Packing House

11. Industry or business

FATHER
12. Name Julian Halkow
13. Birthplace Austria (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Annie
15. Birthplace Austria (City, town, or county) 4 (State or foreign country)

16. (a) Informant Records

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12 1945 (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph Mo

18. (a) Signature of funeral director Webb City Und Co

(b) Address Webb City Mo

19. (a) Aug 10 1945 (Date received local registrar) (b) Mrs Lillie Lagle (Registrar's signature)

1180

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9 year 1945 hour 7 minute 15 P M.

21. I hereby certify that I attended the deceased from July 26, 1945, to Aug 9, 1945, that I last saw him alive on Aug 9, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tuberculosis	
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:

(c) 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 0

23. Signature Jesse E Douglass (M. D. or other)

Address Webb City Mo Date signed 8/9/45

(Licensed Embalmer's Statement on Reverse Side)

45-8-728

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 Myself, ..., Registered Apprentice No. ....., working under my personal supervision.

Signed Clayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Weeb City, 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.