

U.S. No. 2  
FORM-5-43  
Rev. 5-17-39  
J X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31219**

Registration District No. **280** Primary Registration District No. **6964** Registrar's No. **673**

1. PLACE OF DEATH:  
(a) County Platte  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township) Bellevue  
(c) Name of hospital or institution:  
North of Fairfax Airport 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution no. (Specify whether)  
In this community passing through years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State unknown, (b) County \_\_\_\_\_  
(c) City or town unknown,  
(If outside city or town limits, write "RURAL")  
(d) Street No. unknown,  
(If rural, give location)  
(e) Citizen of foreign country? X (Yes or No)  
If yes, name country X

3. (a) PRINT FULL NAME Pono P. Egan, #39085444  
(b) If veteran, name war World War #2  
(c) Social Security No. unknown

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 10  
year 1945 hour 12 minute 15 A.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced unknown  
6. (b) Name of husband or wife unknown  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased unknown  
(Month) (Day) (Year)

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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

3rd degree burns entire body, compound fracture right leg.  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_

10. Usual occupation Staff Sergt.  
11. Industry or business Army

Of autopsy no  
History & Inspection  
22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident 83  
(b) Date of occurrence 9-15-45  
(c) Where did injury occur? Platte County, Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public Place  
(Specify type of place) (e) Means of injury airplane crash

MOTHER FATHER  
12. Name unknown  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant U. S. Army  
(b) Address Kansas City, Mo.  
17. (a) removal (Burial, cremation, or removal) (b) Date thereof 9-20-45  
(Month) (Day) (Year)  
(c) Place: burial or cremation San Francisco, California  
18. (a) Signature of funeral director Stine & McClure  
(b) Address 3235 Gillham Plaza, K. C., Mo.  
19. (a) 9-15-45 (Date received local registrar) (b) ma Public Ballou (Registrar's signature)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

23. Signature Jimmey 3 (M. D. or other) crash  
Address 1424 1/2 ave Date signed 9-16-45

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

**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

*[Handwritten Signature]*

Licensed Embalmer No. 1415

P. O. Address. Ke...

**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.**