

FILED OCT 24 1945
42

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **1107**

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:
2018 Francis St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **no**
In this community **10 years**
years, months or days (Specify whether)

3. (a) PRINT FULL NAME **Frank Bishop**

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 **widower**

6. (b) Name of husband or wife **unknown** 6. (c) Age of husband or wife if alive **1863** years

7. Birth date of deceased **November 1** (Month) (Day) (Year)

8. AGE: Years **81** Months **11** Days **12** If less than one day hr. min.

9. Birthplace **New Market, Missouri** (City, town, or county) (State or foreign country)

10. Usual occupation **Medical Physician**

11. Industry or business **retired**

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 **Mrs W. A. Scott**

(b) Address **324 N 7th, St. Joseph, Mo.**

17. (a) **Burial** (b) Date thereof **10-16-45** (Month) (Day) (Year)

(c) Place: burial or cremation **New Market Mo**

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

(b) Address **St. Joseph, Mo**

19. (a) **10/17/45** (b) **[Signature]** (Date received local registrar) (Registrar's signature)

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. **2018 Francis St**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **13** year **1945** hour **6** minute **30** A. M.

21. I hereby certify that I attended the deceased from **Oct 10** 19**45** to **Oct 11** 19**45** (that I last saw **alive** on **Oct 11** 19**45** and that death occurred on the date and hour stated above.)

Immediate cause of death: **Cerebral Thrombosis**
Due to **arteriosclerosis**
Due to **Diaply Berrigand tumor of prostate**
Other conditions (Include pregnancy within 3 months of death)

Duration
109 1/2
102 1/2

PHYSICIAN

Major findings: Of operations **[check]**
Of autopsy **[check]**
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?
While at work? **[check]** (Specify type of place) (e) Means of injury **[check]**
23. **Charles H. Kemmerly** (M. D. number)
221 Kirkwood Bldg No. **15-1945**

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

1424

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. Sidenfaden For*

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.