S. No. 2
0M—2-43
v. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

33209

FILED NOV 42 1945

State File No. .....

Registration District No. .....

Primary Registration District No. 1000

Registrar's No. 1137

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: 5016 ½ King Hill Ave (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none (Specify whether years, months or days)

In this community Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan

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

(d) Street No. 5016 ½ King Hill Ave (If rural, give location)

(e) Citizen of foreign country? none (Yes or No)

If yes, name country none

3. (a) PRINT FULL NAME HENRY L MAGIN

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Martha R.

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Feb (Month) 22 (Day) 1874 (Year)

8. AGE: Years 71 Months 8 Days 0 If less than one day ..... hr. ..... min.

9. Birthplace St. Joseph Mo (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Swift & CO.

FATHER

12. Name John Magin

13. Birthplace Germany (City, town, or country) (State or foreign country)

MOTHER

14. Maiden name Buchanan

15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Martha R. Magin Wife

(b) Address 5016½ King Hill Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/45 (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

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

(b) Address 6054 Pryor St. Joseph Mo.

19. (a) 10-24-45 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 22nd year 1945 hour 6 minute A. M.

21. I hereby certify that I attended the deceased from Sept 27 1945 to Oct 22 1945 that I last saw him alive on Oct 16 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency — Duration Do not know

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:

(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 Fenton Goodson (M. D. or other)

Address 109 1/4 W. Mo. ave Date signed 10/23/45 ST. JOSEPH

1728

(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. Sidenfaden

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.