

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 2 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34386**

Registration District No. **280**

Primary Registration District No. **6-9-64-4420**

Registrar's No. **19**

1. PLACE OF DEATH:

(a) County **Platte**
(b) City or town **Farley**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **none**
(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) **60 years**

3. (a) PRINT FULL NAME

William Angelbeck

3. (b) If veteran,

name war **none**

3. (c) Social Security

No. **none**

4. **Male**

5. Color or race **White**

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

6. (b) Name of husband or wife **Caroline**

6. (c) Age of husband or wife if alive **85** years

7. Birth date of deceased **April 25 1945**

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

86

5

6

hr.

min.

9. Birthplace

Diehligen

(City, town, or county)

Germany

(State or foreign country)

10. Usual occupation

Farmer retired

11. Industry or business

grain & stock

12. Name

Henry Angelbeck

13. Birthplace

Germany

(City, town, or county)

Germany

(State or foreign country)

14. Maiden name

Sophie Krause

15. Birthplace

Germany

(City, town, or county)

Germany

(State or foreign country)

16. (a) Informant

Wm. H. Angelbeck

(b) Address

Farley Mo

17. (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

Oct 4 - 1945
(Month) (Day) (Year)

(c) Place: burial or cremation

Platte City Mo

18. (a) Signature of funeral director

L. H. Plummer

(b) Address

Parkville Mo

19. (a)

Oct 2, 1945
(Date received local registrar)

(b)

Wm. H. Angelbeck
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Platte**
(c) City or town **Farley**
(If outside city or town limits, write "RURAL")
(d) Street No. **none**
(If rural, give location)
(e) Citizen of foreign country? **yes** (Yes or No)
If yes, name country **Germany**

MEDICAL CERTIFICATION

20. DATE OF DEATH:

Month **October** day **1**

year **45**

hour **3**

minute **A**

M.

21. I hereby certify that I attended the deceased from

Sept

1, 19**45** to **Oct 1**, 19**45**

that I last saw him alive on **Sept 25**, 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death

myocardial failure
due to Cardiac dilatation (angina)
Due to **acute coronary sclerosis**
hypertension
Due to **Senility**

Duration

10 minutes
6 hrs
6 hrs

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?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. J. Counts

(M. D. or other)

Address

Lawrence, Mo

Date signed

Oct 2, 45

AUG 12 1949

FEB 27 1950

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 yes

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

Signed L. H. Francis

Licensed Embalmer No. 3451

P. O. Address Parkville 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.