

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

36706

FILED DEC 7 1945 STANDARD CERTIFICATE OF DEATH

State File No.

1266

Registration District No. 42

Primary Registration District No. 1000

Registrar's No.

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:  
Mo. Methodist Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
(Specify whether  
In this community 4 days  
years, months or days)

3. (a) PRINT  
FULL NAME

Milford B. Zion

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  
Maude E. Zion

6. (c) Age of husband or wife if  
alive 58 years

7. Birth date of deceased August  
(Month)

29 1888  
(Day) (Year)

8. AGE: Years Months Days  
57 2 27

If less than one day  
hr. min.

9. Birthplace Lee County  
(City, town, or county)

Virginia  
(State or foreign country)

10. Usual occupation retired farmer

11. Industry or business farm

12. Name William Zion

13. Birthplace Lee County  
(City, town, or county)

Virginia  
(State or foreign country)

14. Maiden name Eliza Jaynes

15. Birthplace Lee County  
(City, town, or county)

Virginia  
(State or foreign country)

16. (a) Informant Maude E. Zion

(b) Address Fillmore, Mo.

17. (a) burial  
(Burial, cremation, or removal)

(b) Date thereof 11/29/45  
(Month) (Day) (Year)

(c) Place: burial or cremation Centenary Cemetery

18. (a) Signature of funeral director  
Walter B. Hoke & Bowman  
(b) Address 319 South 10th Street,

19. (a) Dec 3-1945 (b) R. J. [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew  
(c) City or town Fillmore  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26th  
year 1945 hour 1 minute 05 A. M.  
21. I hereby certify that I attended the deceased from 11-22-45  
to 11-26-45, 19  
that I last saw him alive on 11-25-45, 19  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Intestinal obstruction  
Due to Chronic indigestion -  
no operation - no autopsy  
Due to

Other conditions Diabetes mellitus  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations None  
Of autopsy None

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 Paul Jorgensen (M. D. or other)  
Address St Joseph, Mo Date signed 11-26-45

(Licensed Embalmer's Statement on Reverse Side)

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

Mr. Paul Fargless  
731 Fargless

### 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 Frank A. Brown

Licensed Embalmer No. 1710

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.**