. S. No. 2
M—9-4-41
v. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 8 1946

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

40523

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1443

**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: Hat Hospital 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 years (Specify whether

In this community 37 years (years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Buchanan 11

(c) City or town St Joseph (If outside city or town limits, write "RURAL") 1

(d) Street No. 6022 Bryor (If rural, give location) 7

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME JOSEPH F. BEAR

3. (b) If veteran, name war ✓

3. (c) Social Security No. —

4. Sex M O

5. Color or race W

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

6. (b) Name of husband or wife ----

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

7. Birth date of deceased Aug. (Month) 21st (Day) 1908 (Year)

8. AGE: Years 37 Months 3 Days 20 If less than one day hr. min.

9. Birthplace Saint Joseph, (City, town, or county) Missouri (State or foreign country)

10. Usual occupation None

11. Industry or business

FATHER
12. Name J. L. Bear
13. Birthplace DeSoto Springs, (City, town, or county) Idaho (State or foreign country)

MOTHER
14. Maiden name Susan B. Weaver
15. Birthplace Forbes (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Hospital record

(b) Address St. Joseph, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Mrs. E. R. Sidenfaden

(b) Address 602 South 10th Street

19. (a) Jan 7-46 (Date received local registrar) (b) H. J. Westlebush (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 11 year 1945 hour 4 minute 15 p.m.

21. I hereby certify that I attended the deceased from Dec 11, 19..., to Dec 11, 1945 that I last saw him alive on On Dec 11, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis Chronic intestinal obstruction

Due to

Due to ✓

Other conditions ✓ (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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 T. A. Connelson (M. D. or other)

Address St Joseph Mo Date signed 12/11/45

(Licensed Embalmer's Statement on Reverse Side)

1478

## 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. Siebenfaden Fo

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.**