

FILED JAN 8 1946 STANDARD CERTIFICATE OF DEATH

State File No. 40625

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1394

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(c) Name of hospital or institution: 517 Concord
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan
(c) City or town St. Joseph
(d) Street No. 517 Concord
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME MORDECAI-OLIVER-ROOT

3. (b) If veteran, name war No
3. (c) Social Security name 496-09-6206

4. Sex M Color W
5. Color or race W
6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife Laura
6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Apr 12 1874
(Month) (Day) (Year)

8. AGE: Years 71 Months 8 Days 11
If less than one day hr. min.

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

10. Usual occupation Emp. St. Joseph

11. Industry or business Hardware Co.

12. Name Horace E. Root

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

14. Maiden name Moby Anderson

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

16. (a) Informant Mrs. J. W. Kariker

(b) Address Los Angeles Calif

17. (a) (b) Date there Dec 16 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cem

18. (a) Signature of funeral director R. T. ...
(b) Address St. Joseph Mo

19. (a) Dec 18 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23
year 1945 hour 1:40 minute a. M.

21. I hereby certify that I attended the deceased from 12/20 1945 to 12/23 1945
that I last saw him alive on 12/23 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza
Pulmonary embolism
Pulmonary thrombosis

Due to Age

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(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 [Signature] (M. D. or other)
Address St. Joseph Mo Date signed 12/23/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1428

MAY 20 1946

MAY 21 1946

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 John Ray Stoney
Licensed Embalmer No. 2435
P. O. Address St Joseph

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.