

S. No. 2  
4-8-43  
5-17-39  
P-1 X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

12205

**FILED** MAY 42

8 1946

STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. ....

Primary Registration District No. 1000

Registrar's No. 388

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: St. Joseph's Hospital 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 13 days  
(Specify whether years, months or days) years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan //  
(c) City or town St. Joseph /  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2106 South 6th St. 7  
(If rural, give location) 0  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country: .....

3. (a) PRINT FULL NAME Charles Bland

3. (b) If veteran, name war No 3. (c) Social Security Don't Know

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

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

7. Birth date of deceased About 1872  
(Month) (Day) (Year)

8. AGE: Years 78 Months ? Days ? If less than one day hr. min. 9

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

10. Usual occupation Not employed

11. Industry or business

MOTHER FATHER {  
12. Name Unknown  
13. Birthplace Unknown Unknown 7  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address St. Joseph, Mo.

17. (a) Burial (b) Date thereof Apr. 2, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (c) Signature of funeral director Wm. J. ...  
(b) Address 6025 King Hill Ave.

19. (a) April 2, 1946 (b) Wm. J. ...  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 1  
year 1946 hour 6 minute 40 a M.

21. I hereby certify that I attended the deceased from March 18,  
1946 to March 31, 1946  
that I last saw him alive on March 31, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the head  
of the pancreas with metastasis  
Other Conditions: Abdominal Ascites  
Jaundice, Arteriosclerosis, and  
Abdominal Ascites

Due to .....  
Other conditions (include pregnancy within 3 months of death) .....

Major findings: Of operations .....  
Of autopsy .....  
PHYSICIAN 468  
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? (c) Means of injury .....

23. Signature Wm. J. ... (r. D. or other) 0  
Address Kirkpatrick Bldg. Date signed 4/2/46

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

11114

3, X

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**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 *Emma Cook*  
Licensed Embalmer No. 4238  
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.**