

**FILED** MAY 8 1946

**STANDARD CERTIFICATE OF DEATH**

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 513

**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  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days)  
In this community 8 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Harold Hise

3. (b) If veteran, name war no  
3. (c) Social Security No. 496-03-6075

4. Sex Male 5. Color or race white  
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 July 20, 1899  
(Month) (Day) (Year)

8. AGE: Years 46 Months 9 Days 6 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Gentry County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business Meeks Recreation

MOTHER FATHER  
12. Name George F. Hise  
13. Birthplace Gentry County, Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary D. Pierce  
15. Birthplace Gentry County, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant George F. Hise  
(b) Address 407 A. St., St. Joseph, Mo.

17. (a) Burial (b) Date thereof 4-28-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Albany, Mo.

18. (a) Signature of funeral director Barry Funeral Home  
St. Joseph, Mo.  
(b) Address \_\_\_\_\_

19. (a) May 6, 1946 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

**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. 407 A. St.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 26  
year 1946 hour 6 minute 50 A.M.

21. I hereby certify that I attended the deceased from April 26  
1946, to April 26, 1946  
that I last saw him alive on April 26, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Delirium Tremens 2 da

Due to Chronic Alcoholism

Due to \_\_\_\_\_

Other conditions Fracture Rt Ankle 3 day  
(Include pregnancy within 3 months of death)

Major findings: PELVICIAN

Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
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. Charvat (M. D. or other) MD  
Address 210 Phys. & Surg. Bldg. Date signed 4/27/46

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

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 Victor J. Barry

Licensed Embalmer No. 4212

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.

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St Joseph  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Harold Hise  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 3

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_ month \_\_\_\_\_ day

7. Birth date of deceased July 20 1946  
(Month) (Day) (Year)

8. AGE: Years 46 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
MEDICAL CERTIFICATION

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Delirium tremens - chb. alcoholism  
Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 4-22-46

(c) Where did injury occur? St Joseph Buchanan Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Tavern

While at work? yes (Specify type of place) \_\_\_\_\_ (c) Means of injury Fall  
23. Signature J. J. Higgins (M. D. or other) MD  
Address 2001 St Joseph Hwy Date signed 10/1

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

12250