

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **19577**

**FILED JUN 12 1946**

Primary Registration District No. **1000**

Registrar's No. **669**

1. PLACE OF DEATH

(a) County Buchanan

(b) City or town St Joseph

(c) Name of hospital or institution: State Hosp # 1  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 5 yrs. 2 mo. 0 ds  
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo

(b) County Jackson

(c) City or town W.C.  
(If outside city or town limits, write "RURAL")

(d) Street No. Keopony Road  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Clarence E Tack exx

3. (b) If veteran, name war —

3. (c) Social Security No. not stated

4. Sex MO

5. Color or race W

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

6. (b) Name of husband or wife r

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

7. Birth date of deceased June 14 1879  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>66</u>	<u>11</u>	<u>24</u>	hr. min.

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

10. Usual occupation retired

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

12. Name Wm Jackson

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

14. Maiden name Josephine Bramlett

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

16. (a) Informant Wm Frank Lane

(b) Address Law City Mo

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

(b) Date thereof 6-10-46  
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Fleeman & Son Inc

(b) Address St Joseph Mo

19. (a) June 10, 1946  
(Date received local registrar)

(b) [Signature]  
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month June day 8  
year 1946 hour 9 minute 0 M.

21. I hereby certify that I attended the deceased from July 19, 1946, to June 8, 1946  
that I last saw him alive on June 7, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary TB

Duration 1 yr

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

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

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

Major findings: Of operations 13/15

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury D

23. Signature [Signature] (M. D. or other) MD

Address State Hosp. St. Joseph Date signed 6/10/46

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

MOTHER FATHER

**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.....

*Robert H. Yapel*

Licensed Embalmer No. ....

*3308*

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.**