

FILED OCT 7 1946

1000

1091

Registration District No. 42

Primary Registration District No. ....

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Buehoun

(b) City or town St Joseph

(c) Name of hospital or institution: Methodist Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days  
(Specify whether years, months or days)

In this community abt 60 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Buehoun

(c) City or town St Joseph

(d) Street No. 1013 Grand Ave  
(If outside city or town limits, write "RURAL" and name of township)

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

If yes, name country.....

3. (a) PRINT FULL NAME CHARLES-MAGNESS

3. (b) If veteran, name war WW 3. (c) Social Security No. 7

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

6. (b) Name of husband or wife Maude 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Dec 24 1872  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>9</u>	<u>2</u>	hr. min.

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

10. Usual occupation Blair-Smith

11. Industry or business Horse Shoes - Ret

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Leon D. Huffstutter

(b) Address RR#4 Agency Road St Joseph

17. (a) (b) Date thereof 9-28-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakland

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 26  
year 1946 hour noon minute 1200 M.

21. I hereby certify that I attended the deceased from 9/24/46 to 9/26/46  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Arrest

Due to .....

Due to .....

Other conditions Hypertrophy of Prostate  
(Include pregnancy within 6 months of death)

Major findings: Of operations 137P

Of autopsy.....

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)

23. Signature Chas. G. ... (M. D. or other)

Address St Joseph Date signed 9/26/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

28445

**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 Roy Stawey*

34 - 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.**