

**FILED MAR 24 1947**

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **367**

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:  
**2313 Locust St**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **none**  
(Specify whether  
In this community **40 years**  
years, months or days)

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. **2313 Locust St**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **Albert G. Clisbee**

3. (b) If veteran, name war **no**  
3. (c) Social Security No. **491-09-8236**

4. Sex **Male** 5. Color of race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Martha** 6. (c) Age of husband or wife if alive **64** years

7. Birth date of deceased **August 23, 1887**  
(Month) (Day) (Year)

8. AGE: Years **59** Months **6** Days **13**  
If less than one day hr. min.

9. Birthplace **Hermitage, Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **Painter**

11. Industry or business **Wm Clisbee**

12. Name **Illinois**

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

14. Maiden name **Mary MCKinsey**

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

16. (a) Informant **Albert T. Clisbee**

(b) Address **1626 1/2 So 11th St, St. Joseph, Mo**

17. (a) **Burial** (b) Date thereof **3-11-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Barry Funeral Home**

(b) Address **St. Joseph, Mo**

19. (a) **3-17-47** (b) **L. L. Jenkins**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **8**  
year **1947** hour **10** minute **10 P** M.

21. I hereby certify that I attended the deceased from **Mar 13 1947** to **Mar 13 1947**  
that I last saw him **alive** on **3/13/47**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** Duration **2 wks**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

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 injury) (e) Means of injury

23. Signature **Wm. Jacobshen** (M. D. or other)

Address **1626 1/2 So 11th St, St. Joseph, Mo** Date signed **3/17/47**

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

MOTHER FATHER

APR 16 1947

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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 Mollie E. Sidenfaden Fox  
Licensed Embalmer No. 4235  
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.**