

No. 2  
-12-45  
5-17-39  
I X47070

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 20136  
Registrar's No. 808

FILED JUL 8 1947  
Registration District No. 42

Primary Registration District No. 1000

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

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:  
Mo. Methodist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
In this community 37 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Samuel E. Hess.  
3. (b) If veteran, name war No  
3. (c) Social Security No. None

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Eva Hess  
6. (c) Age of husband or wife if alive 23 years  
7. Birth date of deceased December 23 1863  
(Month) (Day) (Year)

8. AGE: Years 83 Months 5 Days 28  
If less than one day hr. min.

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

10. Usual occupation Retired salesman

11. Industry or business Unknown

MOTHER FATHER  
12. Name Cyrus Hess  
13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Duncan

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

16. (a) Informant C. W. Hess

(b) Address Kansas City, Missouri

17. (a) Burial (b) Date thereof 6/23/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Belmont Cemetery

18. (a) Signature of funeral director Heaton-Bowman

(b) Address St. Joseph, Missouri

19. (a) 7-3-47 (b) E. G. Jenkins  
(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. 204 West Valley  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21  
year 1947 hour 5 minute 50 A. M.  
21. I hereby certify that I attended the deceased from 6-17-47  
to 6-21-47  
that I last saw him alive on 6-20-47  
and that death occurred on the date and hour stated above.

Immediate cause of death Post-operative Shock Duration 18 hrs.  
Due to Subtrochanteric Fract. Left Femur  
Due to Trauma  
Other conditions genl arteriosclerosis  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: Subtroch Fract.  
Of operations Subtroch Fract.  
Of autopsy 170C  
Underline the cause to which death should be attributed statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) accident  
(b) Date of occurrence 6-17-47  
(c) Where did injury occur? St. Joseph, Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public (Specify type of place) motor  
While at work? yes (e) Means of injury bike

23. Signature Jacob Kulavirli (M. D. or other)  
Address St. Joseph, Mo. Date signed 6-21-47

now collision

056117 JUN 27 1950

JUL 8 1940

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 Eugene Wood  
Licensed Embalmer No. 3804  
P. O. Address 319 So 10th 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.