

No. 2
12-45
17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 15 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3963**
Registrar's No. **287**

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:
State Hospital No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 mos. 24 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME JAMES FRANKLIN ALLINDER

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased 2-11-1871
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-------|--------|------|----------------------|
| ✓ | 77 | 0 | 28 | hr. min. |

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

10. Usual occupation Track laborer

11. Industry or business Railroad Industry

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Ralph Allinder

(b) Address 5900 Winner Road, K. C. Mo.

17. (a) Removal (b) Date thereof Mar. 9, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 1946 Colhoun St., St. Joseph, Mo.

19. (a) 3-10-48 (b) G. L. Jenkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Peurus City
(If outside city or town limits write "RURAL")

(d) Street No. 512 Woodland
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 9
year 1948 hour 12 minute 50 A., M.

21. I hereby certify that I attended the deceased from 3-5-1948 to 3-8-1948
that I last saw him live on 3-8-1948
and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|--|
| <u>Chronic Myocarditis</u> | |
| Due to <u>Gen arterio sclerosis</u> | |
| Due to <u> </u> | |
| Other conditions (include pregnancy within 3 months of death) | |
| Major findings: Of operations <u> </u> | PHYSICIAN Underline the cause to which death should be charged statistically. |
| Of autopsy <u> </u> | |

22. If death was due to external causes, fill in the following:

(c) 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 Forrest Thomas (M. D. owner)
Address State Hospital No. 2 Date signed 3-9-48
St. Joseph, Mo.
W. H. Murray O.D.

Revised

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed.....

Raymond H. Morches

Licensed Embalmer No. 4413 Missouri

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.