

National Office of Vital Statistics

FILED AUG 16 1948

Registration District No. **12**Primary Registration District No. **1000**Registrar's No. **813**

## 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:  
**Missouri Methodist Hospital**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **1 day**  
 (Specify whether  
 In this community **1 day**  
 years, months or days)

## 3. (a) PRINT

FULL NAME **Elmer McAfee**3. (b) If veteran,  
name war. **No**3. (c) Social Security No.  
**No**

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married;  
 divorced. **Single**  
 6. (b) Name of husband or wife. 6. (c) Age of husband or wife if  
 alive. **12** years  
 7. Birth date of deceased. **April 12 1869**  
 (Month) (Day) (Year)

8. AGE: Years **79** Months **3** Days **25** If less than one day  
 hr. min.

9. Birthplace **Evansville Indiana**  
(City, town, or county) (State or foreign country)10. Usual occupation **Retired Farmer**

## 11. Industry or business

12. Name **Charles McAfee**13. Birthplace **Evansville Indiana**  
(City, town, or county) (State or foreign country)14. Maiden name **Elizabeth Baker**15. Birthplace **Evansville Indiana**  
(City, town, or county) (State or foreign country)16. (a) Informant **Mrs. Frank Wagoner**(b) Address **Forest City, Missouri**17. (a) **Burial** (b) Date thereof **Aug 8 1948**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Forbes, MO.**18. (a) Signature of funeral director **James W. Pappas**(b) Address **Oregon, Mo.**19. (a) **8-7-48** (b) **E. C. Jenkins**  
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month **August** day **7**  
 year **1948** hour **8:00** minute **A.M.**

## 2. USUAL RESIDENCE OF DECEASED:

**Missouri** (a) State **Holt** (b) County **44**  
 (c) City or town **Oregon**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **Oregon**  
 (If rural, give location)  
 (e) Citizen of foreign country? **No** (Yes or No)  
 If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **7**  
 year **1948** hour **8:00** minute **A.M.**

21. I hereby certify that I attended the deceased from  
**August 6, 1948** to **August 7, 1948**  
 that I last saw him alive on **August 6, 1948**, 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

## Immediate cause of death

**Bilateral Hydropneumothorax with  
 emphysema and  
 arteriosclerosis** **48 hrs.**

Due to **arteriosclerosis**

Due to **sepsis**

Other conditions: **Fracture Rt arm.** **4 d.**

(Include pregnancy within 3 months of death)

## Major findings:

Of operations **1816**Of autopsy **1816**

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

(a) Accident, suicide, or homicide (specify) **SUPPLEMENTARY**(b) Date of occurrence **INFORMATION**(c) Where did injury occur? **RECORDED**

(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)

While at work? (e) Means of injury

23. Signature **R. M. Bush** (M. D. **ea**)Address **825 Charles** Date signed **8-7-48**

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 Jarvis H. Pittsford  
Licensed Embalmer No. 3192  
P. O. Address Oregon 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. au 9  
Registrar's No. 843

Registration District No. 42

Primary Registration District No. 1000

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:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Elmer Meafes  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 12 (Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days \_\_\_\_\_ (Less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) \_\_\_\_\_  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH Month Aug 1948 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. \_\_\_\_\_  
Immediate cause of death \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence Aug 5, 1948  
(c) Where did injury occur? Oregon Holt Ind.  
(City or town) (County) (State)  
(d) Did injury occur in or about home \_\_\_\_\_ on farm, in industrial place, in public place?  
Home  
While at work? No (Specify type of place) (e) Means of injury Fall on stairway

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

5-22248