No. 2
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 9 1948

Registration District No. 42

MISSOURI DIVISION OF HEALTH
# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1000

State File No. 28957

Registrar's No. 1040

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: 9 hrs (Specify whether years, months or days)
In this community: ~~3 year~~ 9 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: ~~Buchanan~~ Andrew
(c) City or town: Amazonia (If outside city or town limits, write "RURAL")
(d) Street No.: Rt. 1. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: ORA G. ROE
3. (b) If veteran, name war: No
3. (c) Social Security No.: 491-10-4203

4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Bernice
6. (c) Age of husband or wife if alive: 38 years
7. Birth date of deceased: March 14, 1901 (Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 6 | 11 | hr. min. |

9. Birthplace: Versailles, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business: Own farm

MOTHER FATHER
12. Name: John Roe
13. Birthplace: Versailles, Mo. (City, town, or county) (State or foreign country)
14. Maiden name: Elizabeth White
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Bernice Roe
(b) Address: Rt. 1, Box 27, Amazonia, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/27/48 (Month) (Day) (Year)
(c) Place: Burial or cremation: Memorial Park Cem.
18. (a) Signature of funeral director: CLARK FUNERAL HOME Earl Clark
(b) Address: 120 Illinois Ave, St. Joseph, Mo.
19. (a) 10-4-48 (Date received local registrar) (b) E. L. Jenkins (Registrar's signature) 382

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 25 year 1948 hour 9 minute 15 a. M.
21. I hereby certify that I attended the deceased from 9-24, 1948, to 9-25, 1948 that I last saw him alive on 9-25, 1948 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Fracture skull Basal bilateral. | |
| Due to: | |
| Due to: Fall | |
| Other conditions (Include pregnancy within 3 months of death): | |
| Major findings: Of operations: | |
| Of autops.: Skull fracture | |

PHYSICIAN — Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): accident
(b) Date of occurrence: 9-24-48
(c) Where did injury occur? (City or town) Andrew Co. (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? no (e) Means of injury: Fall
23. Signature: Robert C. Long (M. D.)
Address: Savannah Mo Date signed: 9-27-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

## 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 Earl A Clark

Licensed Embalmer No. 4238

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.