

No. 2
5-43
5-17-39
X38671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28968**
Registrar's No. **1028**

FILED OCT 4 1948

Registration District No. _____ 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:
2610 1/2 St. Joseph, Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community **Most of Life**
years, months or days

3. (a) PRINT FULL NAME **Milton B. Teegarden**

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 **Married**

6. (b) Name of husband or wife **Alta May Teegarden**

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

7. Birth date of deceased: **December 28 1862**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
1	85	8	25	_____ hr. _____ min.

9. Birthplace **Ray County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Carpenter**

11. Industry or business **Self**

MOTHER FATHER

12. Name **Jobe Teegarden**

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

14. Maiden name **unk unk**

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

16. (a) Informant **Mrs. Alta Teegarden**

(b) Address **2610 1/2 St. Joseph, Ave. St. Joseph, Mo.**

17. (a) **Burial** (b) Date thereof **9-25-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Auburn Cemetery**

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

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

19. (a) **9-29-48** (b) **Lo B. 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. **2610 1/2 St. Joseph, Avenue**
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **23**
year **1948** hour **8** minute **32** a.m.

21. I hereby certify that I attended the deceased from **July 24 1948** to **Sept. 23 1948**
and that I last saw him alive on **Sept. 22 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Uremia**

Due to **Carcinoma of prostate extending to rectum & sigmoid**

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy **51 B**

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) Mode 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? _____

23. Signature **Leo Rock** (M. D. or D.O.)
Address **King Hill Bldg.** Date signed **9/29/48**

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.....

John Roy Stoney

Licensed Embalmer No. *2435*

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.