

FILED JUL 11 1949

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18653

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>748</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>2 1/2 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Methodist Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1028 Angelique</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>John Sanford</u> b. (Middle) <u>Hart</u> c. (Last) <u>Hart</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 3 1949</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>May 14, 1866</u>	
9. AGE (In years last birthday) <u>83</u>		10. UNDER 1 YEAR Days <u>1</u> Hours <u>19</u>		11. BIRTHPLACE (State or foreign country) <u>Mo. U</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Dekalb</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>Isaac Hart</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Sanford</u>		14. NAME OF HUSBAND OR WIFE <u>Maggie Hart</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Luther Hart</u> ADDRESS <u>Dekalb Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Embolism</u> ANTECEDENT CAUSES <u>Arteriosclerosis</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Terminal Pneumonia</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES ☐ NO ☐			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-30</u> , 19 <u>48</u> , to <u>7-3</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>7-3-49</u> , 19 <u>49</u> , and that death occurred at <u>12:20P</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Signature or title) <u>Clifton Smith M.D.</u>		23b. ADDRESS <u>218 No. 7th St. Joseph, Mo.</u>		23c. DATE SIGNED <u>7-5-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7/6/1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>DeKalb Mo.</u>	
DATE REC'D BY LOCAL REG. <u>July 7, 1949</u>		REGISTRAR'S SIGNATURE <u>E. C. Jenkins</u> 382		25. FUNERAL DIRECTOR'S SIGNATURE <u>Heath-Pearce Funeral Home</u> ADDRESS <u>409 E. 10th St. Joseph Mo.</u>			

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

A. E. Smith

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 _____
_____, Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed *William L. Guckin*
Licensed Embalmer No. *4525*

P. O. Address *3195 10th St. N. Wash. D.C.*

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.