

FILED FEB 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1915

BIRTH NO.		REG. DIST. NO. <u>250</u>		PRIMARY REG. DIST. NO. <u>4374</u>		Registrar's No. <u>3</u>	
1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> COUNTY <u>Nodaway</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clyde</u>		c. LENGTH OF STAY (in this place) <u>Jefferson</u> <u>lifetime</u>		c. CITY OR TOWN <u>Clyde, Mo.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Limits Clyde, Mo.</u>				f. STREET ADDRESS (If rural, give location) <u>0740</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mr. Joseph Albert</u> b. (Middle) <u>Fuchs</u> c. (Last) <u>Fuchs</u>			4. DATE OF DEATH <u>Feb 3 1955</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>May 25 1869</u>	
9. AGE (In years last birthday) <u>85</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>invalid</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Nodaway County Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13a. FATHER'S NAME <u>Carl Fuchs</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Mary Eokstein</u>		14. NAME OF HUSBAND OR WIFE <u>single</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. J. R. Stucker Clyde, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Cardiovascular disease</u> ANTECEDENT CAUSES DUE TO (b) <u>unknown</u> DUE TO (c) <u>unknown</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Hernia mental deficiency, Congenital</u>				INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>Life</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4221</u>					
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. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>12-29</u> , <u>1953</u> , to <u>2-3</u> , <u>1955</u> , that I last saw the deceased alive on <u>1-4</u> , <u>1955</u> , and that death occurred at <u>9.50a m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Deputy or title) <u>Charles D. Berlin M.D.</u>				23b. ADDRESS <u>Stanberry, Missouri</u>		23c. DATE SIGNED <u>2-3-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb 5 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Columba Conception</u>		24d. LOCATION (City, town, or county) (State) <u>Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2-5-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Elva Henshaw</u> 370-0		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Phillips Stanberry</u>			

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

G. Albert R. Conlin

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
~~Signature of Student Embalmer~~

Signed *George F. Shille*

Licensed Embalmer No. *189*

P. O. Address *Stouber*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.