

FILED JUL 7 1944

Registration District No. **72**

Primary Registration District No. **1000**

Registrar's No. **679**

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: **St. Josephs' Hospital** **0**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **4 mo. 16 days**
(Specify whether
 In this community **1 year**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan** **11**
 (c) City or town **St. Joseph** **1**
(If outside city or town limits, write "RURAL")
 (d) Street No. **420 South 8th** **7**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country **0**

3. (a) PRINT WILLIAM M. HECTOR
FULL NAME

3. (b) If veteran, name war **none** 3. (c) Social Security No. **499-16-5832**

0 4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widow**
 6. (b) Name of husband or wife **Hattie Hector** 6. (c) Age of husband or wife if alive **2** years
 7. Birth date of deceased **February 6, 1865**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	79	4	22	hr. min.

9. Birthplace **Rochester Missouri** **0**
(City, town, or county) (State or foreign country)

10. Usual occupation **laborer**

11. Industry or business **General**

MOTHER FATHER { 12. Name **Unknown,**
 13. Birthplace **Unknown,** **9**
(City, town, or county) (State or foreign country)
 14. Maiden name **Unknown,**
 15. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Albert H. Hector**

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

17. (a) **Burial** (b) Date thereof **6/30/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rochester, Mo.**

18. (a) Signature of funeral director **Walter Betole & Bowman**

(b) Address **319 South 10th**

19. (a) **6/29/44** (b) **William S. Pickett**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **28**
 year **1944** hour **3** minute **10** A. M.

21. I hereby certify that I attended the deceased from **May 12**
 19**44**, to **June 28**, 19**44**;
 that I last saw him alive on **June 27**, 19**44**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of cecum and portion of ascending colon**
 Due to **Secondary Anemia**
 Duration **over two months**
 malignant

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings: **H6e**
 Of operations **None**
 Of autopsy **None**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date 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? _____

While at work? _____ (Specify type of place) _____
 (c) Means of injury **0**
 23. Signature **W. M. Latchford** (M.D. or other)
 Address **Social Welfare Board** Date signed **6/30/44**

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Mr. Wayne M. Joubert

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 *Frank A. Brown*

Licensed Embalmer No. *1710*

P. O. Address *St. Joseph*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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