

FILED OCT 13 1947

Registration District No. \_\_\_\_\_ Primary Registration District No. **1000**

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: **State Hospital # 2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: **2 mos 22 days**  
(Specify whether  
In this community **8 yrs.**  
years, months or days)

3. (a) PRINT FULL NAME **ALBERT PANKAU**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **Anna** 6. (c) Age of husband or wife if alive **5** years  
7. Birth date of deceased **July 5 1862**  
(Month) (Day) (Year)

8. AGE: Years **85** Months **3** Days **1** If less than one day hr. min.

9. Birthplace **Gallatin, Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business

12. Name **Joseph Pankau**

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

14. Maiden name **Kapalee**

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

16. (a) Informant **Bertha Happe**

(b) Address **804 1/2 St St Joseph Mo**

17. (a) **Burial** (b) Date thereof **Oct. 8, 1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Joseph's Cemetery - Easton**

18. (a) Signature of funeral director **Herman W. Sidenfaden**

(b) Address **1802 Union St. St. Joseph, Mo.**

19. (a) **10-9-47** (b) **E. L. Johnson**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Buchanan**  
(c) City or town **St. Joseph**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1313 7th St**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **6**  
year **1947** hour **2** minute **35** A. M.

21. I hereby certify that I attended the deceased from **9-29-** 1947, to **10-6-** 1947;  
that I last saw him alive on **10-5-** 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocarditis** Duration **2 days**

Due to **arteriosclerosis 10 years**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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) (e) Means of injury

23. Signature **E. L. Johnson** (M. D. or other)

Address **State Hospital # 2 St Joseph Mo** Date signed **10/6/47**

---

---

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.....

*George A. Herbert*

working under my personal supervision.

....., Registered Apprentice No. *41*

Signed.....

*Elmer Thomas*

Licensed Embalmer No. *2640*

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.**