

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24265**
Registrar's No. **199**

FILED JUL 20 1944

Primary Registration District No. **3008**

1. PLACE OF DEATH:
(a) County **Callaway**
(b) City or town **Fulton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **State Hospital No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **36 yrs 3 m 5 d** (Specify whether years, months or days)
In this community **36 yrs 3 m 5 d**

3. (a) PRINT FULL NAME **Albert Bishop**
3. (b) If veteran, name war **DK** 3. (c) Social Security No. **DK**
4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **DK** **1876**
(Month) (Day) (Year)

8. AGE: Years **65** Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **DK**

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

14. Maiden name **DK**

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

16. (a) Informant **DK**

(b) Address **Buried**

17. (a) **Buried** (b) Date thereof **6/14/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Masonic Cem**

18. (a) Signature of funeral director **DK**
(b) Address **California Mo**

19. (a) **6-12-1944** (b) **Joce Morsinkhoff**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Moniteau**
(c) City or town **California** **14**
(If outside city or town limits, write "RURAL") **2**
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **DK**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **11**
year **1944** hour **11** minute **0** M.
21. I hereby certify that I attended the deceased from **6-1-44** 19, to **6-11-44** 19,
that I last saw him alive on **6-11-44** 19,
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Myocarditis
Due to _____
Arteriosclerosis
Due to _____

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

Major findings:
Of operations **DK**
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) Means of injury _____

Signature **George H. Reuss** (M. D. or other) **MA**

Address **Fulton Mo** Date signed **6/14/44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

14-2-2

RECEIVED

District Health Officer No. 9

District File Number

7-19-44

Date Filed

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

J. E. Friedman

Licensed Embalmer No.

2857

P. O. Address

California no

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.