

REC'D FEB 21 1939

 MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

 1659
 Do not use this space.

1. PLACE OF DEATH

 (a) County BUCHANAN
 (b) Township WASHINGTON
 (c) City ST. JOSEPH

 Registration District No. 85
 Primary Registration District No. 1001
 (d) Street No. ST. JOSEPH'S HOSPITAL
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
Registered No. 57

2. PRINT FULL NAME

 (a) Residence, No. 416 NORMA FILBERT
R.F.D.#6 St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) DIVORCED

 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J.E. FILBERT,
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) FEBRUARY 28, 1895
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 10 20

 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSEWIFE

 9. Industry or business in which work was done, as saw mill, bank, etc. HOME

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ANDREW COUNTY MISSOURI

 FATHER 13. NAME GEORGE JEFFRIES

 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ANDREW COUNTY, MISSOURI

 MOTHER 15. MAIDEN NAME GRACE MCGLOTHAM

 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ANDREW COUNTY, MISSOURI

 17. INFORMANT (ADDRESS) GEORGE JEFFRIES, ST. JOSEPH, MISSOURI.

 18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. AUBURN CEMETERY DATE JAN, 21/1939

 19. FUNERAL DIRECTOR (NAME) (ADDRESS) FLEEMAN & SON, INC. 1946 COLHOUN ST. ST. JOSEPH, MO.

 20. FILED JUN 20, 1939 A. J. Dietrich Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 18, 1939
 22. I HEREBY CERTIFY, That I attended deceased from October 10, 1938, to Jan. 18, 1939

 I last saw him alive on Jan. 18, 1939 Death is said to have occurred on the date stated above, at 1.30 P.

The principal cause of death and related causes of importance were as follows:

Generalized Peritonitis Date of onset 10-12-38
Pelvic abscess 11-20-38
Bilateral Tubo-ovarian Abscess 10-1-38

Other contributory causes of importance:

Secondary anemia Nov. 1938Name of operation Hysterectomy, Oostomy Date of 10-20-38What test confirmed diagnosis? Clinical Was there an autopsy? No
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury, 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Cabray Worley, M.D.(Address) 731 Jason St. St. Joseph, Mo.

10/11/12

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, JOHN E. RUPP

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No. *3986*

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

1659
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
(b) Township _____ Primary Registration District No. 1001 Registered No. 579
(c) City St. Joseph (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Norma Filbert

(a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-18-1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 43 10 20

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

Generalized peritonitis
Plasma abscess 12/19/38
Bilateral Tubo ovarian

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:
abscess. Secondary anemia
Cause of abscess unknown

FATHER 13. NAME

Name of operation No. 6 C. found Date of _____

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

What test confirmed diagnosis? _____ Was there an autopsy? _____

MOTHER 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Where did injury occur? _____ (Specify city or town, county, and State)

17. INFORMANT (ADDRESS)

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL

Manner of injury Cabray Worthy, Inc.
Nature of injury _____

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

20. FILED Mar 9 1939 Cabray Worthy, Inc. Local Registrar

(Signed) Cabray Worthy, M. D.
(Address) 231 Farm at St Joseph Ind

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. REGISTRATION OF DEATHS SHOULD BE MADE IMMEDIATELY UPON DEATH.

SUPPLEMENT

