

REC'D MAR 13 1939

662

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

Do not use this space.

5945

1. PLACE OF DEATH

County Buchanan  
Township  
City St. Joseph

Registration District No.

Primary Registration District No. State Hoop #2

File No.  
Registered No. 156  
St. Ward

2. FULL NAME

Mina Grimes  
(a) Residence, No. State Hospital #2 St. Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 11 mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female  
4. COLOR OR RACE white  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
Est. 27 Unknown Unknown

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
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) Missouri

13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) State Hospital No 2 records

18. BURIAL, CREMATION, OR REMOVAL  
PLACE State Hoop #2 DATE 2-17-39

19. UNDERTAKER (ADDRESS) Platter Funeral Home  
20. FILED Feb 17, 1939 J. M. Littlebush Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 15, 1939

22. I HEREBY CERTIFY, That I attended deceased from February 6, 1939, to February 15, 1939.

I last saw him alive on February 15, 1939. Death is said to have occurred on the date stated above, at 9 A.M.

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

Bilateral Pulmonary Tuberculosis

Other contributory causes of importance:

Name of operation Date of  
What test confirmed diagnosis? X-Ray Was there an autopsy? yes

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) A. H. Powell M. D.  
(Address) State Hospital No 2

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I, John Roy Stamer, Licensed Embalmer No. 2435  
hereby certify that the body referred to on the reverse side of this  
Certificate was embalmed by Was not embalmed  
or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

(Signed)

John Roy Stamer  
LICENSED EMBALMER No. 2435

**NOTE:** The above MUST BE SIGNED BY THE LICENSED EMBALMER IN HIS OWN HANDWRITING.  
(Failure to comply with this regulation is a cause for revocation of license.)