

REC'D APR 11 1939

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

10130  
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85  
 (b) Township Washington Primary Registration District No. 1002 Registered No. 288  
 (c) City St. Joseph (d) Street No. 1105 Henry St.  
 (e) Length of residence in city or town where death occurred 35 yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Sophia Wachter

(a) Residence, No. 1105 Henry St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) December 9, 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
78 3 10

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home  
 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

12. BIRTHPLACE (CITY OR TOWN) Cook County  
 (STATE OR COUNTRY) Illinois

13. NAME Peter Jenawine

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

15. MAIDEN NAME Unknown

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

17. INFORMANT Fred A. Wachter  
 (ADDRESS) R. F. D. #2 St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL Mt. Olivet Cent.  
 PLACE St. Joseph, Mo. DATE Mar. 21, 1939

19. FUNERAL DIRECTOR (NAME) H. O. Sidenfaden & Son  
 (ADDRESS) 1802 Union St. St. Joseph, Mo.

20. FILED 3/20 1939 A. J. Mathias  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 19, 1939

22. I HEREBY CERTIFY, That I attended deceased from 3-17-39, 1939, to 3-18, 1939  
 I last saw her alive on 3-18, 1939 Death is said to have occurred on the date stated above, at 11:30 A.M.  
 The principal cause of death and related causes of importance were as follows:

Coronary Thrombosis

Date of onset  
3-17-39

Other contributory causes of importance:

Hypertension  
Sclerosis general

Name of operation None Date of None  
 What 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? No Date of injury None, 1939  
 Where did injury occur? None  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None  
 Nature of injury None

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

(Signed) Thomas Redmond M.D.  
 (Address) 328 Park Street, St. Joseph, Mo.

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.

8721

**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, .....

..... Elbert E. Harrington ....., or by .....

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\*\*\*\*\*

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

Signed Elbert E. Harrington

Licensed Embalmer No. 3258.

P. O. Address 1802 Union Str. St. Jose

**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.

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1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85  
(b) Township St. Joseph Primary Registration District No. 1001 Registered No. 288  
(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

(a) Residence, No. 1105 Henry 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W-

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 14, 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.

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)

Coronary Thrombosis  
hypertension  
General Sclerosis  
General Arterio-sclerosis

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

Other contributory causes of importance:  
General Sclerosis  
General Arterio-sclerosis

13. NAME

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

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

15. MAIDEN NAME

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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

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

17. INFORMANT (ADDRESS)

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

18. BURIAL, CREMATION, OR REMOVAL

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

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_ (Signed) Thomas Redmond M.D.

20. FILED June 15, 1939 H. J. Neatbrook Local Registrar

(Address) Kirkpatrick Bldg.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

