

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. 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.

RECEIVED SEP 12 1939

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

28650
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. 881
(c) City ST. JOSEPH (d) Street No. 3006 - NORTH 7TH St.
(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 5 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME JOSETTA - RICHARDS - DAVIS -

(a) Residence, No. 3006 - NO. SEVENTH 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 Jacob B Davis

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 29 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 10 29

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) aug 1 1939
11. Total time (years) spent in this occupation 40

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Galena Center Ind.

13. NAME James L. Richards

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

15. MAIDEN NAME Margaret Oberholtzer

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

17. INFORMANT (ADDRESS) Jay G Davis
St Joseph Mo.

18. BURIAL, CREMATION, OR REMOVE PLACE Ashland DATE aug 30 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Roy Stamey
St Joseph Mo

20. FILED 8/29 19 9 W. Nestleburg
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 28, 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 25, 1939, to Aug 28, 1939
I last saw her alive on Aug 26, 1939. Death is said to have occurred on the date stated above, at 1:15 p. m.
The principal cause of death and related causes of importance were as follows:

Chronic Endocarditis Unknown

Other contributory causes of importance: None

Name of operation None Date of ✓
What test confirmed diagnosis? Clinical Was there an autopsy? No

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) Jay G Davis M. D.
(Address) St. Joseph Mo.

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.....

John H. Hurley
working under my personal supervision.

....., Registered Apprentice No.

Signed.....

John H. Hurley
Licensed Embalmer No. *4050*

P. O. Address.....

2335 St Joseph

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.