

REC'D SEP 12 1939

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

28673

Do not use this space.

859

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 86
 (b) Township Washington Primary Registration District No. 5127
 (c) City St. Joseph (d) Street No. Route # 6 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 40 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 620 Amanda Rosella Cross

(a) Residence, No. Route # 6, Kirschners Add. St. Route 6 Kirschners Add.
 (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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Charles P. Cross</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb. 16, 1874 (1874)</u>				
7. AGE	YEARS <u>65</u>	MONTHS <u>6</u>	DAYS <u>4</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>			
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>own home</u>			
	10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....			
12. BIRTHPLACE (CITY OR TOWN) <u>Clyde</u> D (STATE OR COUNTRY) <u>Missouri</u> C				
FATHER	13. NAME <u>John Hockman</u> 9			
	14. BIRTHPLACE (CITY OR TOWN) <u>Stanberry</u> (STATE OR COUNTRY) <u>Missouri</u>			
MOTHER	15. MAIDEN NAME <u>Elizabeth Strange</u>			
	16. BIRTHPLACE (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY) <u>Unknown</u>			
17. INFORMANT <u>Charles P. Cross</u> (ADDRESS) <u>Route # 6, Kirschners Add.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>King Hill Cem</u> DATE <u>Aug 22 39</u>				
19. FUNERAL DIRECTOR (NAME) <u>Clark Mortuary</u> (ADDRESS) <u>5025 King Hill Ave</u>				
20. FILED <u>Aug 23, 1939</u> <u>A. J. Seckelbach</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 20, 1939 19

22. I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1939, to Aug 20, 1939
 I last saw her..... alive on Aug 19, 1939... Death is said to have occurred on the date stated above, at.....10:00a..m.
 The principal cause of death and related causes of importance were as follows:

Acute MyocarditisDate of onset
Aug 15/39

Other contributory causes of importance:

Acute Cholera-TyphosicAug 17

Name of operation..... Date of.....
 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?..... 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) H. A. Robertson, M. D.
 (Address) 621 1/2 King Hill Ave
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 Aug. 20, 199

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Earl A. Clark

Licensed Embalmer No. 3476

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.