

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

42830
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
 (b) Township St. Joseph Primary Registration District No. 1001 Registered No. 1308
 (c) City St. Joseph (d) Street No. St. Joseph's Hospital 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 32 yrs. - mos. - ds. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME 236 Della Hectorne

(a) Residence, No. 919 1/2 Frederick Ave 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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) December 5, 1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 0 14

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Seamstress
 9. Industry or business in which work was done, as saw mill, bank, etc. St. Joseph's Hosp.
 10. Date deceased last worked at this occupation (month and year) Dec. 1939 11. Total time (years) spent in this occupation ?

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

13. NAME Justin Hectorne

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

15. MAIDEN NAME Mary Elizabeth McInerney

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

17. INFORMANT Julian Hectorne Mo.
 (ADDRESS) 919 1/2 Frederick Ave. St. Joseph

18. BURIAL, CREMATION, OR REMOVAL MT. OLIVET CRT.
 PLACE St. Joseph, Mo. DATE DEC. 22, 1939

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

20. FILED Dec 21, 1939 H.J. Seestrich
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from Oct 3, 1939, to Dec 19, 1939
 I last saw her alive on Dec 19, 1939 Death is said to have occurred on the date stated above, at 8:45 P.M.
 The principal cause of death and related causes of importance were as follows:

Carcinoma Less of Oct 39
bronchus. (Primary).

Contributory causes of importance:
Cholelithiasis 46 -

Name of operation Cholecholelitomy Dec 19
 What test confirmed diagnosis? am 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) Franklin H. DeGau M. D.
85 (Address) Temperance Bldg.

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 hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

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

Signed *Robert P. Clarkson*

Licensed Embalmer No. 4028

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.