V. S. No. 2
50M—11-10-39
R. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1940

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 6003

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 205

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**

(a) County Buchanan

(b) City or town Saint Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Saint Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution three Months
(Specify whether years, months or days)

In this community

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Buchanan

(c) City or town Saint Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 1105½ North 5th Street
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Mrs. Margaret Celia Mann

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Michael Mann

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased March (Month) 24 (Day) 1858 (Year)

8. AGE: Years 81 Months 10 Days 29 If less than one day ____ hr. ____ min.

9. Birthplace Saint Louis, (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Charles Lavelette
13. Birthplace Saint Louis, (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown, (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Father Charles Nowland
(b) Address 519 North 10th Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Febr. 24 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director E. R. Siebenfaden (Mrs.)
(b) Address 602 South 10th Street

19. (a) 2/23/40 (Date received local registrar) (b) H. J. Westtebuck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 2 day 21 year 1940 hour 10:00 minute 20 P. M.

21. I hereby certify that I attended the deceased from May (Approx.) 1939 to Feb. 21 1940; that I last saw him alive on Feb 21 1940 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Bronchopneumonia | Week |
| Due to: Rheumatic Heart Disease | ? |
| Due to: Arteriosclerosis General | ? |
| Due to: Portal cirrhosis (mild) | ? |
| Hypertention | ? |

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations ✓
Of autopsy ✓

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Wm. B. Rose M.D. (M. D. or other)
Address Kirkpatrick Bldg. Date signed 2-23-40

(Licensed Embalmer's Statement on Reverse Side)

## 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 _____

Hollie E. Sidenfaden, Registered Apprentice No. 145,

working under my personal supervision.

Signed R. V. West

Licensed Embalmer No. 3876

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.**