

FILED MAR 11 1940

State File No. _____

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 224

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:
St. Josephs Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME ROSE MENDELL

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Morris Mendell 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased UNKNOWN (Month) ABOUT (Day) 1885 (Year)

8. AGE: Years Est 55 Months ? Days ? If less than one day hr. _____ min. _____

9. Birthplace (unk) (City, town, or county) Russia (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business HOME

MOTHER FATHER

12. Name UNKNOWN

13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant MR. MORRIS MENDELL

(b) Address 824 S. 9th St Joseph

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-27-40 (Month) (Day) (Year)

(c) Place: burial or cremation SHARPE SYSTEM

18. (a) Signature of funeral director FLEEMAN & SON, INC.

(b) Address St Joseph, Mo.

19. (a) FEB 27 1940 (Date received local registrar) (b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan

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

(d) Street No. 824 S. 9th.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 26 day 26 year 1940 hour 7 minute 10 P.M.

21. I hereby certify that I attended the deceased from Feb. 25, 1940, to Feb 26, 1940; that I last saw him alive on Feb 26, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion and dilatation of heart

Due to _____

Due to _____

Other conditions Diabetes mellitus
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

85 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address 620 Franklin Date signed 2-27-40

Duration 2 days

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

11
5
7

Handwritten marks and scribbles in the top right corner.

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.

Not Embalmed.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.