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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10228

MAR APR 12 1940

Registration District No. 85 | Primary Registration District No. 1001 | Registrar's No. 309

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

11
57
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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: 1719 NORTH 2ND (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: — In this community: ABOUT 45 YRS. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: BUCHANAN

(c) City or town: ST. JOSEPH. (If outside city or town limits write "RURAL")

(d) Street No.: 1719 NORTH 2ND (If rural, give location)

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

8. (a) PRINT FULL NAME: LIDA SEVERNS 165

8. (b) If veteran, name war: —NO—

3. (c) Social Security No.: —NO—

4. Sex: Female

5. Color or race: W Lt

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

6. (b) Name of husband or wife: Frank (Divorced) (SEVERNS)

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

7. Birth date of deceased: March (Month) 15 (Day) 1860 (Year)

8. AGE: Years	Months	Days	If less than one day
80	0	2	..... hr. ..... min.

9. Birthplace: Edgeville, Iowa (City, town, or county) (State or foreign country)

10. Usual occupation: at home

11. Industry or business:

MOTHER FATHER

12. Name: John Foy

13. Birthplace: Do not Know (City, town, or county) (State or foreign country)

14. Maiden name: Julia Wright

15. Birthplace: Do not Know (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs J. B. Gillings

(b) Address: St Joseph Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-19-1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Mora Cem.

18. (a) Signature of funeral director: Roy Storey

(b) Address: St Joseph Mo

19. (a) Mar. 18, 1940 (Date received local registrar) (b) H. J. Nestlebaud (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17 year 1940 hour 8:25 minute a M.

21. I hereby certify that I attended the deceased from March 17, 1940, to March 17, 1940, that I last saw her alive on March 17, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral apoplexy — Duration: 4 hours

Due to: High blood pressure and Chronic Bright's

Due to:

Other conditions (Include pregnancy within 3 months of death): 321

Major findings: Of operations: ✓

Of autopsy: None

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): NO

(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: Leroi Beck M.D. (M. D. or other)

Address: King Hill Bldg St Joseph Mo Date signed: 3/18/40

(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 John H. Hurley, Registered Apprentice No. ....., working under my personal supervision.

Signed John H. Hurley

Licensed Embalmer No. 4050

P. O. Address 2328 S. St Joseph Ave

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.