

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

14356  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Buchanan Registration District No. 85  
 (b) Township \_\_\_\_\_ Primary Registration District No. 1007 Registered No. 447  
 (c) City St. Joseph 3 (d) Street No. St. Hospital # 2 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 yrs. 1 mos. 15 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jessie Freemont Helm  
 (a) Residence, No. 3306 Penn. St. 0 St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. ~~SINGLE~~ MARRIED, WIDOWED, OR Married  
(write the word)  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. W. Helm  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) November 5, 1861  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
78 5 12  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as saw mill, bank, etc. None  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sidney, Ill /  
 FATHER 13. NAME John Black  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn /  
 MOTHER 15. MAIDEN NAME Miriam Black ?  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn /  
 17. INFORMANT Records State Hosp # 2  
 (ADDRESS) St. Joseph, Mo.  
 18. BURIAL, CREMATION, OR (REMOVAL TO Danville Ill)  
 PLACE Cremation DATE April 19th 1940  
 19. FUNERAL DIRECTOR (NAME) FREEMAN & SON, INC.  
 (ADDRESS) 1946 Calhoun St. St. Joseph, Mo.  
 20. FILED April 19 1940 H. J. Nestledunak (Address) State Hosp # 2  
 Local Registrar St. Joseph, Mo

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 17 1940  
 22. I HEREBY CERTIFY, That I attended deceased from March 11 1940 April 17 1940  
 I last saw her alive on April 17 1940. Death is said to have occurred on the date stated above, at 9:29 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Hypertensive Cardiovascular Disease  
Senile Psychosis  
 Other contributory causes of importance: None  
 Name of operation None Date of \_\_\_\_\_  
 What test confirmed diagnosis? Chin'hat Was there an autopsy? no  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no 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) D. P. Johnson \_\_\_\_\_, M. D.  
 (Address) State Hosp # 2  
St. Joseph, Mo

Date of onset  
1935

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.

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**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.....

*C. G. Swan*

Licensed Embalmer No. 4082

P. O. Address.....

*St Joseph*

**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.**