

No. 2
13-40
17-39
X23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24678**

Registration District No. **853** Primary Registration District No. **1001** Registrar's No. **803**

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: **Missouri Methodist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
(Specify whether years, months or days)
In this community **2 years**

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. **3245 Jackson**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Maura Mary Ochs**
(b) If veteran, name war **None**
(c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **25th**
year **1940** hour **I;00** minute **30a.** M.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Charles F. Ochs**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 21, 1871**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 23, 1940** to **July 25, 1940**
that I last saw her alive on **July 24, 1940**
and that death occurred on the date and hour stated above.
Immediate cause of death **Pneumonia, Toxar**
Duration **3 days**

8. AGE: Years Months Days If less than one day
69 **4** **4** hr. min.

Other conditions **arterio-sclerosis**
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

9. Birthplace **Greenville, Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**
11. Industry or business _____

MOTHER FATHER { 12. Name **Benjamin Thurston**
13. Birthplace **Unknown, Illinois**
(City, town, or county) (State or foreign country)
14. Maiden name **Adelaide Martin**
15. Birthplace **Cape Girardeau, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Wm J. Scamony**
(b) Address **3245 Jackson Street**
17. (a) **Burial** (b) Date thereof **7/26/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Jo. Mem. Park Cem.**
18. (a) Signature of funeral director **W. J. Scamony**
(b) Address **319 S. 10th Street, St. Joseph**
19. (a) **7-26-40** (b) **A. J. Nestor**
(Date received local registrar) (Registrar's signature)

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **E. M. Shores** (M. D. or other) _____
Address **317 W. 11th Street, St. Joseph** Date signed **7-25-40**

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

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 July 25

Registered Apprentice No. _____

working under my personal supervision.

Signed W. M. S. [Signature]

Licensed Embalmer No: 3-7

P. O. Address: 319 So. [Signature]

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, fact should be so stated above.