

No. 2  
4-13-40  
5-17-39  
X23159

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27945  
Registrar's No. 839

Registration District No. 85

Primary Registration District No. 1001

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

1. PLACE OF DEATH BUCHANAN

(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: STATE HOSPITAL N. 3  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community, ✓  
years, months or days)

3. (a) PRINT FULL NAME Vashti McCafferty 216

3. (b) If veteran, name war ✓

3. (c) Social Security No. None

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife William

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

7. Birth date of deceased April 14 1849  
(Month) (Day) (Year)

8. AGE: Years 91 Months 3 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Louisa County Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Housewife

MOTHER FATHER { 12. Name James Joy

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

14. Maiden name Mary Jane Mosby

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

16. (a) Informant Miss Cecil Crawford

(b) Address 709 North 24 St. Joe. Mo.

17. (a) removal (b) Date thereof August 2, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Creston, Iowa

18. (a) Signature of funeral director Hatter Meierhoffer

(b) Address 1302 Faraon, St. Joseph, Missouri

19. (a) Aug 2 1940 (b) H. H. H. H. H.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 3415 Chestnut St.  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 1 year 1940 hour 7:35 minute P.M.

21. I hereby certify that I attended the deceased from July 1, 1940 to Aug. 11, 1940.  
that I last saw her alive on Aug 1, 1940, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia (Senility) Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? 85

While at work? At home (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature H. H. H. H. H. (M. D. or other) MD.  
Address State Hospital No. 2 Date signed 8-2-40

**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

*H. H. Kelly*

Licensed Embalmer No.

*3946*

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, fact should be so stated above.**