

SEP 16 1940
Registration District No. 85

Primary Registration District No. 1001

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

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: 413 Mason 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 25 years
years, months or days)

3. (a) PRINT FULL NAME Arminda Keling Cross 620

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 Widow

6. (b) Name of husband or wife John Cross 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 15, 1842
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>97</u>	<u>7</u>	<u>21</u>	hr. _____ min.

9. Birthplace Gossport Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Own home

MOTHER FATHER { 12. Name Tom Keling

18. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Rebeckah Cotter

15. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant John C. Cross
(b) Address Route 7, St. Joseph, Mo.

17. (a) Burial (b) Date thereof Aug. 9, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethel Cem.

18. (a) Signature of funeral director Clark Mortuary 85

(b) Address 502 1/2 King Hill Ave.

19. (a) Aug 8-8-1940 (b) A. R. Johnson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) 0 Missouri (b) County Buchanan

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

(d) Street No. 413 Mason
(If rural, give location)

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

MEDICAL CERTIFICATION

Aug. 6

20. DATE OF DEATH: Month _____ day _____
year 1940 hour 4 minute 00 p. M.

21. I hereby certify that I attended the deceased from July 22
1940 to Aug 6 1940
that I last saw her alive on Aug 5 1940
and that death occurred on the date and hour stated above.

Immediate cause of death:
Paralytic cerebral hemorrhage
Cholesterol heart
Grav. arterio sclerosis
Due to _____
Duration
1 yr
5 yrs
5 yrs

Due to _____

Other conditions (include pregnancy within 3 months of death) None

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? _____

(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature A. R. Johnson (M. D. or other) _____
Address 502 1/2 King Hill Date signed 8/8/40

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, ~~xxxx~~ Aug. 6, 1940

....., Registered Apprentice No.
working under my personal supervision.

Signed Earl A. Clark

Licensed Embalmer No. 3476

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.