

S. No. 7
4-13
5-17
1-22

Registration District No. 85 Primary Registration District No. 1001

11
5
7
WRITE PLAINLY—USE UNFADING, BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County BUCHANAN
(b) City or town ST-JOSEPH
(c) Name of hospital or institution MO-METH. HOSPITAL
(d) Length of stay: In hospital or institution 1 DAY
In this community 33 YRS

3. (a) PRINT FULL NAME LYNNE-JEFFRIES
3. (b) If veteran, name war 200
3. (c) Social Security No. 200

4. Sex Female
5. Color White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John W. Jeffries
6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased Apr 23 1907

8. AGE: Years 33 Months 3 Days 20
If less than one day hr. min.

9. Birthplace St Joseph MO

10. Usual occupation Housewife

11. Industry or business
12. Name Lee Woolley
13. Birthplace Athens Ohio
14. Maiden name Olive Chester
15. Birthplace Waverly Ill

16. (a) Informant John W. Jeffries
(b) Address St Joseph Mo

17. (a) Burial, cremation, or removal Burial
(b) Date thereof Aug 15 1940

18. (a) Signature of funeral director Roy Slaney
(b) Address St Joseph Mo

19. (a) Date received local registrar 8/14/40
(b) Registrar's signature J. G. Nestle

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County BUCHANAN
(c) City or town ST-JOSEPH (RURAL)
(d) Street No. RFD #2
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 13
year 1940 hour 12 minute 01 A.M.

21. I hereby certify that I attended the deceased from 8/12 1940 to 8/13 1940
that I last saw alive on 8/12 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Eclampsia Ectopic

Due to Hemorrhage

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings: Of operations Julia, Riv. Mchrs, 2000 E.E. Hemorrhage
Of autopsy Yes

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)

(b) Date of occurrence 5

(c) Where did injury occur?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(e) Means of injury

23. Signature J. Slaney (M. D. or other)
Address 2644 St Joseph Mo Date signed 8/13/40

14213
00
132

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
Aug 13 1940, Registered Apprentice No. _____
working under my personal supervision.

Signed John H. Hurley
Licensed Embalmer No. 4050

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27989**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **891**

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

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St Joseph**
(c) Name of hospital or institution:
(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 **Lynne Jeffries**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **33** Months **3** Days **20** If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **Nov. 20, 1940** (Date received local registrar) (b) **A. Meathurst** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **13** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Ectopic Pregnancy**
about 8 weeks, Ruptured Tube
 fetus still in tube,
Hemorrhage

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings of operations **fetus six weeks**
2000 C.C. Hemorrhage
Of autopsy **yes**

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) _____

(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 **J. F. Stoney** (M. D. _____)

Address _____ Date signed **11/19/40**

SUPPLEMENTAL

