No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31430

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 985

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

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: St. Joseph's Hospital,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 30 years,
years, months or days)

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. 1202 North 25th. Street,
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Anna Dorothea Jones,
3. (b) If veteran, name war None,
3. (c) Social Security No. None,
4. Sex Feamle
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed,
6. (b) Name of husband or wife George W. Jones,
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased December 1, 1876 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
63	9	7	____ hr. ____ min.

9. Birthplace New Cambria, (City, town, or county) Missouri, (State or foreign country)
10. Usual occupation At Home,
11. Industry or business
FATHER
12. Name Charles Lampe,
13. Birthplace Unknown, (City, town, or county) Germany, (State or foreign country)
MOTHER
14. Maiden name Mary C. Becker,
15. Birthplace Unknown, (City, town, or county) Germany, (State or foreign country)
16. (a) Informant Carl J. Lampe
(b) Address New Cambria, Mo.
17. (a) removal (Burial, cremation, or removal) (b) Date thereof 9/9/40 (Month) (Day) (Year)
(c) Place: burial or cremation New Cambria, Mo.
18. (a) Signature of funeral director Healon Bishop Bowman
(b) Address 319 So. 10th. Street, Funeral Home
19. (a) Sept 9 1940 (Date received local registrar) (b) A J Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 8th.
year 1940 hour 4:00 minute 05 a.M.
21. I hereby certify that I attended the deceased from Jan, 1938, to 9/8, 1940
that I last saw her alive on 9/2, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	6 hrs
Due to Cerebral arteriosclerosis	
Due to Nephritis Chronic	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy —

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?
85 (Specify type of place)
While at work? — (e) Means of injury —
23. Signature [signature] (M. D. or other) DMD
Address St. Joseph Mo. Date signed 9/9/40

(Licensed Embalmer's Statement on Reverse Side)

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 Sept. 8-

....., Registered Apprentice No.....

working under my personal supervision.

Signed Wm. E. Summerfield

Licensed Embalmer No. 5007

P. O. Address 519 S. 1st St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.