

12-2
12-40
7-39
DEC 10 1940

Registration District No. **85**

Primary Registration District No. **1001**

1. PLACE OF DEATH:
(a) County **Buchanan**
(b) City or town **St. Joseph**
(c) Name of hospital or institution:
1817 Mitchell Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **None**
(Specify whether
In this community **60 years.**
years, months or days)

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

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **August 1, 1865**
(Month) (Day) (Year)

8. AGE: Years **75** Months **3** Days **16**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Thomas Valentine**

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

14. Maiden name **Anna** ? ? ?

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

16. (a) Informant **Rob't Valentine**

(b) Address **1817 Mitchell Ave, St. Joseph,**

17. (a) **Burial** (b) Date thereof **Nov. 19, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olivet Cemetery**

18. (a) Signature of funeral director **H. O. Sidenfaden & Son**

(b) Address **1802 Union Str. St. Joseph, Mo**

19. (a) **11-18-1940** (b) **H. O. Sidenfaden**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **1817 Mitchell Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **17th**
year **1940** hour **8** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **Nov. 17, 1940**, to **Nov. 17, 1940**; that I last saw her alive on **Nov. 17th, 1940** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Arteriosclerosis**

Due to _____

Due to _____

Other conditions (Includes pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? **Yes**

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Harold J. Brunner** (M. D. or other) _____
Address **825 Chin. St. Joseph, Mo** Date signed **11-18-40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

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

working under my personal supervision.

Signed.....

Olson E. Hodges

Licensed Embalmer No.....

2729

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.