

7-39
K23159

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: **STATE HOSPITAL No. 2**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **46 days**
 (Specify whether years, months or days) **46 days**
 In this community **3**

3. (a) PRINT FULL NAME **Mary Rosey**
 3. (b) If veteran, name war **no**
 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Frank** 6. (c) Age of husband or wife if alive **???** years
 7. Birth date of deceased **July 14 1886**
 (Month) (Day) (Year)

8. AGE: Years **54** Months **4** Days **9**
 If less than one day hr. min.

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

10. Usual occupation **House wife**

11. Industry or business **House wife**

12. Name **Joe Stoyall**
 13. Birthplace **Culbrop Bohemia**
 (City, town, or county) (State or foreign country)

14. Maiden name **Mary Conway**
 15. Birthplace **Culbrop Bohemia**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Hospital records**
 (b) Address **State Hospital No. 2**

17. (a) **Removal** (b) Date thereof **11-23-40**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **specimen box**

18. (a) Signature of funeral director **W. M. Daugherty**
 (b) Address **Marceline Mo 45**

19. (a) **Nov. 23, 40** (b) **W. M. Daugherty**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Linn**
 (c) City or town **Marceline**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **0**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. **not known** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **22**
 year **1940** hour **4:30** minute **9** A. M.

21. I hereby certify that I attended the deceased from **October 7**, 1940, to **November 22**, 1940,
 that I last saw her alive on **November 22**, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death **Stature Epileptica** Duration **1 day**
Aspiration pneumonia 3 days

Due to **1940**

Other conditions **Structural Melancholia** Sept. 1940
 (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) **accident**
 (b) Date of occurrence **11/20/40**
 (c) Where did injury occur? **St. Joseph Buchanan Mo.**
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Institutional Hospital

While at work? **no** (Specify type of place)
 (e) Means of injury **aspirated vomitus**

23. Signature **W. M. Daugherty** (M. D. or other)
 Address **State Hospital No. 2** Date signed **11/23/40**

1857

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.....

Dale Bunch

Licensed Embalmer No.....

4088

P. O. Address.....

Marceline 7

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

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