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

FILED JUN 10 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19560 ~~17263~~

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 505

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 6 mo. 2 day (Specify whether

In this community 24 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan

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

(d) Street No. 2844 Jules (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME KATE MORAD

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife CHARLES MORAD

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased June (Month) 28 (Day) 1893 (Year)

8. AGE: Years 47 Months 10 Days 10 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Samuld Brinkwater
13. Birthplace Cameron (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Nancy Moore
15. Birthplace Cameron (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Hospital Records

(b) Address State Hospital #2 St. Joseph Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5--10--41 (Month) (Day) (Year)

(c) Place: burial or cremation ASHLAND CEMETERY C.

18. (a) Signature of funeral director FLEEMAN & SON INC.

(b) Address St. Joseph, Mo.

19. (a) 5-9-1941 (Date received local registrar) (b) W. J. Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8 year 1941 hour 7 minute 20 A.M.

21. I hereby certify that I attended the deceased from March, 1941, to May 8, 1941; that I last saw her alive on May 8, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Syphilitic Meningo encephalitis — Duration 2 yrs (?)

Due to —

Due to —

Other conditions Psychosis c̄ Syphilitic Meningoencephalitis (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? (Specify type of place)

85 While at work? (e) Means of injury

23. Signature Kenneth Thompson (M. D. or other) M. D.

Address State Hospital #2 St. Joseph Date signed 5-8-41

(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~~ Me

, Registered Apprentice No.

working under my personal supervision.

Signed Geo E Daniel

Licensed Embalmer No. 3300

P. O. Address St Joseph Mo

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.