No. 2
1-4-41
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X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27846

FILED SEP 10 1941

Registration District No. 1001

Primary Registration District No. 1001

Registrar's No. 838

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: Doctors Office Phys & Surgs. Bldg. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)

In this community: 12 years

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.: 723 S. 7th. (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME: DOROTHY ATTEBURY

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: Married

6. (b) Name of husband or wife: Russell Attebury

6. (c) Age of husband or wife if alive: 37 years

7. Birth date of deceased: April (Month) 8th. (Day) 1913 (Year)

8. AGE: Years 28 | Months 4 | Days 11 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: Housewife

11. Industry or business: Home.

FATHER
12. Name: E. M. FOSTER
13. Birthplace: IOWA (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: UNKNOWN
15. Birthplace: UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Russell Attebury

(b) Address: 723 S. 7th. St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-22-41 (Month) (Day) (Year)

(c) Place: burial or cremation: Memorial Park

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

(b) Address: St. Joseph, Mo.

19. (a) Aug. 22, 1941 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19th year 1941 hour 4 minute 00 P.M.

21. I hereby certify that I attended the deceased from 8-16-41, 19__, to 8-19, 1941, that I last saw her alive on 8-19, 1941, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Heart failure	
Due to: following nose operation with	
Due to: local anesthetic	
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? ____ (Specify type of place)

While at work ____ (e) Means of injury ____

23. Signature: H. L. Kenney (M. D. or other) M.D.

Address: St. Joseph Mo. Date signed: 8/20/41

(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 Dann

Licensed Embalmer No. 3300

P. O. Address St Joseph M

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.

S. No. 2B
I—8-21-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27846

Registration District No. 85 Primary Registration District No. 10-01 Registrar's No. 838

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:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Dorothy Attebury

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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 Months Days If less than one day hr. 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. Day 16 year 1941 hour minute M.

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

Immediate cause of death Heart failure — Duration

Due to following nose operation with local anesthetic

Due to no malignancy

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Crooked nose external and deflected septum

Of autopsy

PHYSICIAN (Underline the cause to which death should be charged statistically.)

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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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

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

St. Joseph, Mo