

FILED FEB 14 1942

State File No. _____

Registration District No. _____

Primary Registration District No. 1001

Registrar's No. 70

1. PLACE OF DEATH:

(a) County Burhanon
(b) City or town St Joseph Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Joseph's Hosp.
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 3 Days Hosp
(Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Burhanon
(c) City or town St Joseph Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 1111 Burman
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SHERRY LOU HATHAWAY

3. (b) If veteran, name war no 3. (c) Social Security No. 90

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug 23 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 4 27 hr. min.

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

10. Usual occupation Child

MOTHER FATHER { 11. Industry or business _____

12. Name Wm Edward Hathaway

13. Birthplace St Joseph Mo
(City, town, or county) (State or foreign country)

14. Maiden name Margie Ward

15. Birthplace St Joseph Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. H. Ward

(b) Address 804 1/2 N 10th

17. (a) Burial (b) Date thereof Jan 22, 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director FLEEMAN MORTUARY, INC

(b) Address St Joseph Mo

19. (a) Jan 22, 1942 (b) J. T. J. Neelbush
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20
year 1942 hour 6 minute A.M.

21. I hereby certify that I attended the deceased from Jan 16
1942, to Jan 20, 1942

that I last saw her alive on Jan 19, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Brain tumor

Due to _____

Due to _____

Other conditions optic atrophy
(Include 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?

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

23. Signature H. P. Petersen (M. D. or other) MD
Address St Joseph Mo Date signed Jan 20
1942

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

20

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.....

Jan 20 1942

....., Registered Apprentice No.

working under my personal supervision.

Signed *John A. Hurley*

Licensed Embalmer No. *4050*

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.

Registration District No. 85

Primary Registration District No. 1001

Registrar's No.

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph

(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
(years, months or days)

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 Sherry L Hathaway

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 20 year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

4. Sex F

5. Color or race W

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

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

7. Birth date of deceased Aug 23 1900
(Month) (Day) (Year)

8. AGE: Years 1 Months 4 Days 17 min. _____
(If less than one day)

Due to Brain tumor

Due to Malignant

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 54R

Of autopsy _____

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

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

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature H. C. Petersen (M. D. or other) _____
Address 706 Francis St Joseph, Mo Date signed 3-1-42

SUPPLEMENTARY

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

MOTHER FATHER

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

