. S. No. 2
M—1-4-41
v. 5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1942

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 1783

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 105

**1. PLACE OF DEATH:**

(a) County Buchanan,

(b) City or town Saint Joseph, (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 605 No. 11th. Street Mrs. Grace M. Ball Nursing Home, (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 years, (Specify whether

In this community 65 years, years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri, (b) County Buchanan,

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

(d) Street No. 1117½ Church Street, (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Margaret Blackford Yates,

3. (b) If veteran, name war None, 3. (c) Social Security No. None,

4. Sex Female 1 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed, 2

6. (b) Name of husband or wife J. Press Yates, 6. (c) Age of husband or wife if alive years

7. Birth date of deceased August 19, 1867, (Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 12 If less than one day hr. min.

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

10. Usual occupation At Home,

11. Industry or business

FATHER
12. Name Michael Henry Blackford, 4
13. Birthplace Unknown, Ireland, (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Christie, 4
15. Birthplace Unknown, Ireland, (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. James W. Breen

(b) Address 1117½ Church Street,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/42, (Month) (Day) (Year)

(c) Place: burial or cremation Weston, Mo.

18. (a) Signature of funeral director Weston-Bigelow & Bowman Funeral

(b) Address 319 So. 10th. Street, Home

19. (a) 2/2/42 (Date received local registrar) (b) H J Nestlebush (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month January day 31st. year 1942. hour 1:00 minute 25 p.M.

21. I hereby certify that I attended the deceased from Dec 7, 1941, to Jan 31, 1942, that I last saw her alive on 1-28, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: (1) Intestinal Obstruction from probable malignancy of the descending colon — Duration 2 mo

Due to (2) Hypertention (arteriosclerotic)

(3) Cerebrovascular accident (Haemorrhage) — 3 mo

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

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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 Wm. B. Post M.D. (M. D. or other)

Address St. Joseph, Mo. Date signed 2-1-42

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(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 1-31-47

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

working under my personal supervision.

Signed Wm. E. Summerfield

Licensed Embalmer No. 3807

P. O. Address 319 So 10th 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.**