

FILED SEP 11 1942

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 854

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: St Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: 1 month in hospital or institution. (Specify whether years, months or days)

In this community 1 year
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 38 Gentry

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

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MATTIE - PIERCE

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29
year 1942 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from Aug 30, 1942 to Aug 29, 1942
that I last saw her alive on Aug 29, 1942
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color White

6. (a) Name of husband or wife James 6. (c) Age of husband or wife if alive _____ years
divorced wid.

7. Birth date of deceased Mar 2 1870
(Month) (Day) (Year)

Immediate cause of death Hypertensive Cardiovascular renal disease with uremia.

Due to _____

Due to _____

8. AGE: Years 72 Months 5 Days 27
If less than one day _____ hr. _____ min.

Other conditions fractured clavicle
(Include pregnancy within 3 months of death)

9. Birthplace Antley County MO
(City, town, or county) (State or foreign country)

10. Usual occupation at home

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Saphath, Reuben.

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name unn.

15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Pierce

(b) Address all any mo.

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? _____

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-42
(Month) (Day) (Year)

(c) Place: burial or cremation all any mo.

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature S. Saphirtein (M. D. or other) no
Address 620 7 avenue Date signed 8-29-42

18. (a) Signature of funeral director W. J. Starnes

(b) Address St Joseph, MO

19. (a) 8-29-42 (Date received local registrar) (b) W. J. Starnes (Registrar's signature)

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

1943

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..... *John Roy Slaney*
Licensed Embalmer No..... *2435*
P. O. Address..... *St Joseph 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26744
Registrar's No. 854

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(c) Name of hospital or institution: St Joseph Hosp
(d) Length of stay: In hospital or institution 1 mo
In this community 1 mo

3. (a) PRINT FULL NAME Matthe Preis

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive 2 18 20 years

7. Birth date of deceased mo (Month) 2 (Day) 18 20 (Year)

8. AGE: Years 72 Months 5 Days 2 (If less than one day, min.)

9. Birthplace mo (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 (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(d) Street No.....
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1942 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from 9 1942 that I last saw him alive on 9 1942 and that death occurred on the date and hour stated above.

Immediate cause of death hypertension
cardiovascular
renal disease with
uremia

Due to.....
Due to.....
Other conditions fractured clavicle
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations.....
Of autopsy 131a
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.....
(c) Where did injury occur? St Joseph Buch. mo
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Fall out of bed
While at work? (Specify type of place) (c) Means of injury.....

23. Signature M. H. Prosten (M. D. or other)
Address..... Date signed.....

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

SUPPLEMENTARY

T. HARRY SAFERSTEIN, M. D.

OFFICE PHONE 2-8113
ST. JOSEPH,

423 KIRKPATRICK BLDG.
REG. NO. 185

RESIDENCE PHONE 2-8687
MISSOURI

FOR _____

DATE _____

ADDRESS _____

R_x *Death was not due to accident,
but the accident ~~of~~ was an
event during her last illness.*

TAKE THIS TO
CRONER'S PHARMACY
629 SO. EIGHTH STR.
PHONE 4-2675 ST. JOSEPH, MO.
PROMPT FREE DELIVERY

M. D.

NEVER OFFER THIS PRESCRIPTION TO A FRIEND FOR A SEEMINGLY SIMILAR AILMENT; IT IS YOUR PERSONAL PRESCRIPTION, PREPARED FOR YOUR SPECIFIC ILLNESS AT THIS PARTICULAR TIME.