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9-4-41  
5-17-39  
X29484

State File No. ....

**REC OCT 21 1942**

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 943

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 33 yrs. 8 mos. 4 days  
(Specify whether years, months or days)

In this community 13 yrs. 5 mos. 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

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

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

If yes, name country 0

3. (a) PRINT FULL NAME SUSIE LAND

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

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

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Buchanan Mo. 1874  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>un.</u>	<u>un.</u>	hr. .... min.

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

10. Usual occupation housewife

11. Industry or business 9

MOTHER FATHER

12. Name unknown unknown

13. Birthplace " " 2  
(City, town, or county) (State or foreign country)

14. Maiden name unknown unknown

15. Birthplace " " 2  
(City, town, or county) (State or foreign country)

16. (a) Informant Reson's State Hospital #2

(b) Address Saint Joseph, Missouri

17. (a) Burial (b) Date thereof Oct 6 42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation State Hospital #2

18. (a) Signature of funeral director Fleeman

(b) Address St. Joseph, Mo.

19. (a) 10-6-42 (b) W. H. Henry  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2  
year 1942 hour 2:30 minute a. M.

21. I hereby certify that I attended the deceased from Jan 15 1942 to Oct 2 1942  
that I last saw h. or alive on Oct 2 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia Duration 2 days

Due to .....

Due to .....

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? .....

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

23. Signature W. H. Henry (M. D. or other) 10-6-42  
Address State Hospital #2, St. Joseph, Mo. Date signed 10-6-42

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

1250

**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 P. Hawley  
Licensed Embalmer No. 1050  
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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33247  
Registrar's No. 943

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St Joe  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hosp # 2  
(If not in hospital or institution, write street number or location)  
(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

Susie Land

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 \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_

(Month)

(Day)

(Year)

8. AGE:

Years 68

Months

Days

If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country) mo.

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) \_\_\_\_\_

(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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_

year 1942

hour \_\_\_\_\_

minute \_\_\_\_\_

M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_

19 \_\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_

and that death occurred on the date and hour stated above

immediate cause of death hypostatic

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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)

(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 \_\_\_\_\_

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

SUPPLEMENTARY

