

33250

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED NOV 7 1942

Registration District No.

Primary Registration District No. 1000

Registrar's No. 820

1. PLACE OF DEATH:

(a) County Rushannon

(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 # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 1/2 (Specify whether years, months or days)

In this community 2 yrs mos 27 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Livingston

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

(d) Street No. 1001 Maple St
(If rural, give location)

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

3. (a) PRINT FULL NAME Anna Loe

3. (b) If veteran, name war nil

3. (c) Social Security No. nil

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 8 year 1942 hour 5 minute 10 A. M.

21. I hereby certify that I attended the deceased from Jan 15 1942 to Feb 8 1942
that I last saw her alive on Feb 7 1942
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Jacob Loe 6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased: Feb 4 1860
(Month) (Day) (Year)

Immediate cause of death Hypostatic pneumonia of base left lung Duration 2 days

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

8. AGE: Years 82 Months 8 Days 4 If less than one day hr. min.

9. Birthplace Livingston Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business at home

MOTHER FATHER

12. Name Jacob Ashbrook

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

14. Maiden name Unknown

15. Birthplace Licking Co Ky (City, town, or county) (State or foreign country)

16. (a) Informant Mrs H J Ashbrook

(b) Address 1001 Maple St Chillicothe Mo

17. (a) Burial (b) Date thereof 10/10/1942
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 13th. & Faraon St., St. Joseph, Mo.

19. (a) 10-10-42 (b) Rose Hays
(Date received local registrar) (Registrar's signature)

PHYSICIAN

Major findings: Of operations

Of autopsy No

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 [Signature] (M. D. or other)

Address State Hospital # 2 Date signed 10/19/42

1233 (Licensed Embalmer's Statement on Reverse Side)

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

2
41
7-39
X29484

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 *Emma Clark*.....

Licensed Embalmer No. 4238 Missouri.....

P. O. Address St. Joseph, Missouri.....

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.

N. 7B
4-21-41
5-1 K2222

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3320-0
Registrar's No. 820

Registration District No. 42 Primary Registration District No. 1000

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Anna Lee
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 widowed

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

7. Birth date of deceased Feb. 4 1882
(Month) (Day) (Year)

8. AGE: Years 82 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 _____

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)
(Burial, cremation, or removal) (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 _____ (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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 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 pneumonia in congestive edema of left foot (thromb)

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

Major findings:
Of operations _____
Of autopsy _____

Duration _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

