

No. 2
1-4-41
5-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1543

State File No.

Registration District No. 2542

Primary Registration District No. 1001/000

Registrar's No. 116

1. PLACE OF DEATH:

(a) County BUCHANAN

(b) City or town ST. JOSEPH

(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 16 days (Specify whether years, months or days)

In this community 16 days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

(c) City or town Kansas City Mo

(d) Street No. 3215 Campbell
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME Anna E. Blake

3. (b) If veteran, name war V

3. (c) Social Security No. V

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30
year 1943 hour 9 minute 35 P.M.

21. I hereby certify that I attended the deceased from 1-14-43
19. to 1-30 19.43

that I last saw her alive on 1-30-43
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race White

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

6. (b) Name of husband or Not known 6. (c) Age of husband or wife if deceased
alive..... years

7. Birth date of deceased: Aug 17 1853
(Month) (Day) (Year)

Immediate cause of death Brancho pneumonia Duration 1 day

8. AGE: Years 90 Months 5 Days 13 If less than one day hr. min.

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 107

Of autopsy.....

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

10. Usual occupation Housewife

11. Industry or business V

12. Name Peter Blake

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

14. Maiden name Anna E. Spear

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

16. (a) State Hosp. Administration blank

(b) Address Daughter St Joseph Mo

17. (a) Removal (b) Date thereof 1-31-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Trenton, Missouri

18. (a) Signature of funeral director John W. Wagner

(b) Address Kansas City, Missouri

19. (a) 1-31-43 (b) Rae Hergog
(Date received local registrar) (Registrar's signature)

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 3

23. Signature B.T. Sweeney & E.H. Wagner MD

Address State Hosp # 21 St Joseph, Mo Date signed 1/30/43

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

1233

(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.....

Will be embalmed by me....., Registered Apprentice No.....
working under my personal supervision.

Signed *Cecil R. Matthes*.....

Licensed Embalmer No. *3807*.....

P. O. Address *Kansas City, 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.