-9-4-41
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X2948

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1648

FILED FEB 5 1943

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 84

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

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: Mo Methodist 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Gentry

(c) City or town King City Mo 38 (If outside city or town limits, write "RURAL")

(d) Street No. 2 (If rural, give location) 0

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

If yes, name country 1

3. (a) PRINT FULL NAME Sallie Ann Quell

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F-1

5. Color or race Cau

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife J J Quell

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

7. Birth date of deceased Apr (Month) 29 (Day) 1864 (Year)

8. AGE: Years 78 Months 8 Days 25 If less than one day hr. min.

9. Birthplace (City, town, or county) Ky-1 (State or foreign country)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Joseph L. Hulet
13. Birthplace (City, town, or county) Ky-1 (State or foreign country)

MOTHER
14. Maiden name Elizabeth Simpson
15. Birthplace (City, town, or county) Ky-1 (State or foreign country)

16. (a) Informant Agnes Quell

(b) Address King City Mo

17. (a) Remove (Burial, cremation, or removal) (b) Date thereof 1-25-43 (Month) (Day) (Year)

(c) Place: burial or cremation King City Mo

18. (a) Signature of funeral director R. G. Taggart

(b) Address King City Mo

19. (a) 1-25-43 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24 year 1943 hour 11 minute 5 P M.

21. I hereby certify that I attended the deceased from Jan 19, 1943, to Jan 24, 1943 that I last saw her alive on Jan 24, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic pneumonia	
Due to Cerebral hemorrhage	6 day
Hypertension	
Due to Arteriosclerotic heart disease	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature H. S. Conrad (M. D. or other)

Address St Joseph Mo Date signed 1-25-43

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.....

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

working under my personal supervision.

Signed R. G. Taggart

Licensed Embalmer No. 2563

P. O. Address R. G. Taggart

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1648

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 84

SUPPLEMENTARY

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:
(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 Sallie Ann Quell

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 April 29 1864
(Month) (Day) (Year)

8. AGE: Years 78 Months 8 Days 25 If less than one day hr. min.

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 4
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Bronchial Pneumonia

Due to Cerebral Hemorrhage Hypertension

Due to arterio sclerosis heart disease

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

107

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)
(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 H. S. Conrad (M. D. or other)
Address Date signed