S. No. 2
—1-4-41
5-17-39
X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17421

FILED JUN 8 1943 ~~3542~~

Registration District No. ____ Primary Registration District No. ~~1001~~ 1000 Registrar's No. 533

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

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

(d) Length of stay: In hospital or institution 32 yrs 6 mos 2 days (Specify whether years, months or days)

In this community yes

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 110 East 5th (If rural, give location)

(e) Citizen of foreign country? Yes 65 yrs. (Yes or No)

If yes, name country Germany

3. (a) PRINT FULL NAME Mary Probst

3. (b) If veteran, name war No

3. (c) Social Security No. nil

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife not given

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

7. Birth date of deceased Feb. (Month) 23 (Day) 1859 (Year)

8. AGE: Years 84 Months 2 Days 19 If less than one day ____ hr. ____ min.

9. Birthplace Germany 4 (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business at home

FATHER
12. Name not given
13. Birthplace Germany 4 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name not given
15. Birthplace not given 9 (City, town, or county) (State or foreign country)

16. (a) Informant State Hosp records

(b) Address St Joseph Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 5-13-43 (Month) (Day) (Year)

(c) Place: burial or cremation City Cem.

18. (a) Signature of funeral director Heaton Begole & Bowman

(b) Address St Joseph Mo.

19. (a) May 13, 1943 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ~~12th~~ 12th day May year 1943 hour 5 minute 40 P.M.

21. I hereby certify that I attended the deceased from Jan 15, 1942, 19__, to May 12, 1943 that I last saw her alive on May 12, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial pneumonia	2 days
Due to advanced age and dysentary	4 days
Due to Don't know	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 2 C	
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 [signature] (M. D. or other)

Address State Hospital #2 Date signed 5/12/43

12 33 (Licensed Embalmer's Statement on Reverse Side) St Joseph, Mo.

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 James A Moles

Licensed Embalmer No. 3296

P. O. Address St Joseph

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.