

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20823

State File No. _____

Registrar's No. _____

Registration District No. 22

Primary Registration District No. 1000

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:
Rosary Hill Nursing Home, 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days, (Specify whether
In this community 70 years, years, months or days)

3. (a) PRINT FULL NAME Mary M. Ainge

3. (b) If veteran, name war None, 3. (c) Social Security No. None

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

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

7. Birth date of deceased February 10, 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 4 8 _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

12. Name William C. Stahl

13. Birthplace Hessen, Nasau, Germany
(City, town, or county) (State or foreign country)

14. Maiden name Caroline Ickstatt

15. Birthplace Hessen, Nasau, Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lawrence J. Powers

(b) Address 2911 Francis Street, St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/43
(Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery, Weston, Buchanan Co., Mo.

18. (a) Signature of funeral director Michael A. Bowman

(b) Address 319 So. 10th Street, St. Joseph, Mo.

19. (a) June 19/43 (b) Rose Heigoy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town Saint Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2911 Francis
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18th
year 1943 hour 7:00 minute _____ p. a. m.

21. I hereby certify that I attended the deceased from June 8th, 1943 to June 18th, 1943
that I last saw her alive on June 13th, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (Broncho) Duration about 4 days

Due to Influenza 14 days

Due to _____

Other conditions (Include pregnancy within 3 months of death) 330

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 Dr. E. E. M. D. (M. D. or other) M. D.

Address St. Joseph, Mo. Date signed 6/19/43

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

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 C. Moles

Licensed Embalmer No.

3296

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.