

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20874**
Registrar's No. **688**

ED JUN 29 1943
Registration District No. **1003**

Primary Registration District No. **1003**

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:
2018 Frances
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **7 Years**
(Specify whether years, months or days)

In this community **8 Years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **MARY A MCKERRON**

3. (b) If veteran, name war **No**

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 **James G McKerron**

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

7. Birth date of deceased **Jan. 5 1865**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
78	5	21	hr. _____ min.

9. Birthplace **Fulton Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Patrick Ford**

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

14. Maiden name **known**

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

16. (a) Informant **Dr. J. L. McKerron**

(b) Address **2821 Francis, St. Joseph, Mo**

17. (a) **Burial**
(Burial, cremation, or removal)

(b) Date thereof **June 28 43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **Arvuan W. Dideny**

(b) Address **1802 Union, St. Joseph, Mo.**

19. (a) **6-28-43**
(Date received local registrar)

(b) **Arvuan W. Dideny**
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**

(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")

(d) Street No. **2821 Felix**
(If rural, give location)

(e) Citizen of foreign country **no** (Yes or No)

If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **26**
year **1943** hour **12** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **Dec. 1942** to **June 1943**
that I last saw her alive on **June 21**, 19**42**
and that death occurred on the date and hour stated above.

Immediate cause of death **Mitral Insufficiency**

Due to **Cerebral Hemorrhage**

Duration
5yrs.
3yrs.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

928

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 **J. R. Ellitt** (M. D. or other) **M. D.**
Address **8016 Francis, St. Joseph, Mo.** Date signed **6-27-43**

Elliot
801 1/2 France

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 supervisor.

Signed John G. Hurlley
Licensed Embalmer No. 4050
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.