

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH: Buchanan

(a) County Buchanan

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

(c) Name of hospital or institution: Missouri Methodist Hospital

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

(d) Length of stay: In hospital or institution. 4 days  
(Specify whether years, months or days)

In this community 69 years  
(Specify whether years, months or days)

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. 1014 South 9th Street  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs. Alva Adelia Day

3. (b) If veteran,  name war \_\_\_\_\_ 3. (c) Social Security No. 491-09-4223

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased February 6, 1874  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	69	4	20	hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name William Shepherd

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

14. Maiden name Fanny Stone

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

16. (a) Informant Mrs. Lorene Lee,

(b) Address Route #4, St. Joseph, Mo.

17. (a) Burial Burial (b) Date thereof June 28, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director E. R. Sidenfaden

(b) Address 602 South 10th Street

19. (a) 6-28-43 (b) Rose Storgoy  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25 year 1945 hour 5 minute 45 A. M.

21. I hereby certify that I attended the deceased from June 21, 1943, to June 25, 1943, that I last saw her alive on June 25, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death: Manipulated femoral head - ruptured distal end of femoral shaft - gangrene of ilium

Due to: Gangrene of ilium

Due to: Gangrene of ilium

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

Duration 1 week

6-24-43

Major findings: Gangrene of ilium

Of operations: 2 ormentum

Of autopsy: 22a

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: W. L. Lee (M. D. or other) \_\_\_\_\_

Address: St. Joseph Mo Date signed: 6-24-43

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

MOTHER FATHER

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**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 *Mollie E. Sidenfaden Fox*  
Licensed Embalmer No. *04235*  
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.**