S. No. 2
OM—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 11 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

27731

State File No. .....

Registration District No. 42 | Primary Registration District No. 1000 | Registrar's No. 895

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: St Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 65 Years

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.: 612 So 11th
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Fannie Joffe
3. (b) If veteran, name war: No
3. (c) Social Security No. .....
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: A.J.
6. (c) Age of husband or wife if alive: 84 years
7. Birth date of deceased: October (Month) 1863 (Year) (Day)
8. AGE: Years 80 | Months | Days | If less than one day ..... hr. ..... min.
9. Birthplace (City, town, or county): Russia 6 (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business .....
MOTHER FATHER
12. Name: I. Simpson
13. Birthplace (City, town, or county): Russia 6 (State or foreign country)
14. Maiden name: Unknown
15. Birthplace (City, town, or county): Russia 6 (State or foreign country)
16. (a) Informant: I.E.Joffe
(b) Address: St Joseph, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-9-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Bani Yaakov Cemetery
18. (a) Signature of funeral director: Fleeman & Son Inc.
(b) Address: 1946 Colhoun St.
19. (a) 8-9-43 (Date received local registrar) (b) Rose Hegoy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 8 year 1943 hour 6 minute 55 P.M.
21. I hereby certify that I attended the deceased from July 25, 1943 to Aug. 8, 1943 and that I last saw her alive on Aug. 8, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	14 days
Due to: Generalized arteriosclerosis	2 yrs.?
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: None
Of autopsy: None

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: Gabray Worley (M. D. ~~or other~~) M.D.
Address: St Joseph, Mo. Date signed: 8-9-43

(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 Robert H Gaple

Licensed Embalmer No. 3308

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.