

No. 2  
-2-4  
17-  
X35697

FILED NOV 9 1943 42

Registration District No. \_\_\_\_\_ Primary Registration District No. 1000

1. PLACE OF DEATH:

(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:  
2434 South 6th Street Nursing Home  
(If not in hospital or institution, write street number or location)

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

In this community 68 years

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. 2434 South 6th Street  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Mrs. Josephine Helen Cozad

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. NONE

4. Sex Female / race White 5. Color or White

6. (a) Single, widowed, married. 2 divorced Widowed

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

7. Birth date of deceased. March 3, 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

77 7 21 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Alegan County Michigan  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Chandler B. Jones

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

14. Maiden name Sarah Ann Woods

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

16. (a) Informant Mrs. Robert Glidewell

(b) Address 1007 South 11th Street, St. Joseph, Mo.

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

(c) Place: burial or cremation Mount Hope Cemetery

18. (a) Signature of funeral director Wm. E. R. SIDENPADEN

(b) Address 602 South 10th Street, St. Joseph, Mo.

19. (a) 10-27-43 (b) Rose Hays  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 24th  
year 1943 hour 4:10 minute A. M.

21. I hereby certify that I attended the deceased from October 19, 1943 to October 19, 1943; that I last saw her alive on October 19, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Senile dementia 1 year  
Arteriosclerosis 10 yrs.  
Paralysis 9 months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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 Charles J. H. Hays, M.D.  
Address Social Welfare Board Date 10/26/43

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 *Mollie E. Sidenfaden*

Licensed Embalmer No. *4235*

P. O. Address *St. Joseph, Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1174

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1174

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:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. (Specify whether

In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Josephine H. Egard

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 1 1/2 years

7. Birth date of deceased mar 3 1866  
(Month) (Day) (Year)

8. AGE: Years 77 Months 7 Days \_\_\_\_\_ (Unless than one day) min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day \_\_\_\_\_  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Senile dementia Duration \_\_\_\_\_

interossclerosis

Due to Paralysis Hemiplegia 5 days

Soft attack

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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 Charles H. Werner (M. D. or other)

Address 221 Kirkpatrick Bldg Date signed 11-18-1943

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

SUPPLEMENTARY

MOTHER, FATHER

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