

S. No. 2
 M-2.43
 5-17-39
 X33567

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED DEC 8 1943

State File No. 3778E
 Registrar's No. 1237

Registration District No. _____

Primary Registration District No. 1000

1. PLACE OF DEATH: Buchanan

(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 3 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 011

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

(d) Street No. 1011 Grand Ave.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MARY GEISNER

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 8
 year 1943 hour 2 minute 50A M.

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced, single 0

6. (b) Name of husband or wife _____

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

7. Birth date of deceased March 13 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from November 5, 1943, to November 8, 1943, that I last saw her alive on November 7, 1943, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	73	7	25	br. _____ min.

Immediate cause of death: Cerebral hemorrhage
 Duration 3 days

9. Birthplace Scott county 0 Missouri
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

10. Usual occupation seamstress (retired)

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

11. Industry or business McDonaldald Mfg. Co.

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Social Welfare Records

22. If death was due to external causes, fill in the following:

(b) Address St. Joseph, Mo.

(a) Accident, suicide, or homicide (specify) _____

17. (a) - burial (b) Date thereof 11/11/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence _____

(c) Place: burial or cremation Mt. Olivet Cemetery

(c) Where did injury occur? _____
(City or town) (County) (State)

18. (a) Signature of funeral director: _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(b) Address 319 South 10th

While at work? _____
(Specify type of place) (e) Means of injury

19. (a) 11/3/43 (b) Rose Heigoy
(Date received local registrar) (Registrar's signature)

23. Signature: _____ (M. D. or other) D. _____
 Address Social Welfare Board Date signed 11/9/43

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

1233

St. Joseph, Mo

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 Elmer Thomas
Licensed Embalmer No. 2640
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.