

State File No. ....

Registrar's No. 93

Registration District No. 1005

Primary Registration District No. 1005

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: State Hospital, St. Joseph Mo  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 1/2 yrs 2 mos 28 days  
(Specify whether years, months or days)

In this community 1 1/2 yrs 2 mos 28 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 3223 Central St Mo  
(If rural, give location)

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

3. (a) PRINT FULL NAME Mary Frances Febber

3. (b) If veteran, name war Nil

3. (c) Social Security No. ....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1/30 day 30  
year 1944 hour 1:30 minute a M.

21. I hereby certify that I attended the deceased from Jan 17 1944 to Jan 30 1944  
that I last saw her alive on Jan 28 1944  
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years (Day) (Year)

7. Birth date of deceased: July 3 1905  
(Month) (Day) (Year)

Immediate cause of death Intestinal obstruction after hours

Due to 12262

Due to .....

Other conditions (Includes pregnancy within 5 months of death) .....

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

38	6	27	hr. min.
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9. Birthplace Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

Major findings: Intestinal obstruction

Of operations .....

Of autopsy .....

PHYSICIAN ---  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business .....

12. Name Frank Jetter

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

14. Maiden name Mary Glad

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

16. (a) Informant Mrs. Mary Jetter

(b) Address 3223 Central St Mo

17. (a) Burial (b) Date thereof 1-30-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation KC Mo.

18. (a) Signature of funeral director Quirk & Tobin

(b) Address KC Mo.

19. (a) 1-30-44 (b) Arce Herzog  
(Date received local Registrar) (Registrar's signature)

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 0

23. Signature C. E. Cassins (M. D. or other) Mo  
Address State Hospital #2 St. Joseph Date signed 1/30/1944

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.....

*Charles M Quinn*

Licensed Embalmer No.....

*3774*

P. O. Address.....

*KC, 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.**