

S. No. 2
1-9-4-41
5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 9 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

2122

State File No.

Registrar's No. 83

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:
 (a) County: Buckner
 (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 2
 (If not in hospital or institution, write street number & location)
 (d) Length of stay: In hospital or institution: 2 yrs 3 mos 13 days (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Mo. (b) County: Lafayette
 (c) City or town: Dwight
 (If outside city or town limits, write "RURAL")
 (d) Street No.: Family farm (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country: 0

3. (a) PRINT FULL NAME: Dicie Ellen Norton

3. (b) If veteran, name war: nil 3. (c) Social Security No.: nil

4. Sex: Female 5. Color or race: White 6. (a) Single, widowed, married, divorced: 2 widowed

6. (b) Name of husband or wife: Not given 6. (c) Age of husband or wife if alive: 14 years

7. Birth date of deceased: May 14 1870 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>8</u>	<u>9</u>	hr. min.

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

10. Usual occupation: None

11. Industry or business: none at home

MOTHER FATHER

12. Name: Not given
 13. Birthplace: Mo. (City, town, or county) (State or foreign country)
 14. Maiden name: Not given
 15. Birthplace: Mo. (City, town, or county) (State or foreign country)

16. (a) Informant: John P. Smith

(b) Address: Waller City, Mo.

17. (a) Removal (b) Date thereof: 1/25/1944 (Month) (Day) (Year)

(c) Place: burial or cremation: Buckner, Missouri.

18. (a) Signature of funeral director: Walter Meierhoffer

(b) Address: 1302 Faraon St., St. Joseph, Mo.

19. (a) 1-25-44 (b) Rose Deigoog (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1/23 day year 1944 hour 8 minute 10 P. M.

21. I hereby certify that I attended the deceased from Jan 17 1944 to Jan 23 1944 that I last saw him alive on Jan 23 1944 and that death occurred on the date and hour stated above

Immediate cause of death: Hypertensive Hemorrhage Duration: 2 days

Due to: Arteriosclerosis

Due to: Don't know

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: O. L. Cousins (M. D. or other)

Address: State Hospital 2, St. Joseph, Mo. Date signed: 1/23/44

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

1233

(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.....

Albert B. Harrington

Licensed Embalmer No..... 3268 Missouri

P. O. Address..... St. Joseph, Missouri.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 83

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 Dicie E. Harten

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 m

6. (b) Name of husband or wife _____

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

7. Birth date of deceased May 14 1870
(Month) (Day) (Year)

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

9. Birthplace _____
(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 April Day 2 Year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Hypostatic pneumonia

Due to coronary aneurysm

Due to heart failure

Other conditions not hypertensive or uremic
(Include pregnancy within 3 months of death)

Major findings: Of operations 96

Of autopsy _____

Duration 2 days

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? 66 Collins (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTAL

MENTAL

FILED

FILED

2/22