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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 10 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10443

State File No. _____

Registration District No. 92

Primary Registration District No. 1850

Registrar's No. 340

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:
2603 Monterey St. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 43 yrs years, months or days)

3. (a) PRINT FULL NAME Isabelle Hales

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

4. Sex Female 5. Color or race White

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

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

7. Birth date of deceased Sept 25 1851
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>92</u>	<u>6</u>	<u>2</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name William Bogart

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

14. Maiden name Cervilla Hood

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

16. (a) Informant Miss Rose Hales

(b) Address St Joseph, Mo.

17. (a) Burial (b) Date thereof 3-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Perrin Cem

18. (a) Signature of funeral director FLEEMAN & SON, INC.

(b) Address St Joseph, Mo.

19. (a) 3-29-44 (b) Rose Hergatz
(Date received local registrar) (Registrar's signature)

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. 2603 Monterey
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27
year 1944 hour 10 minute 30 A M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw her alive on 3/27/44, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Patric Hemorrhage Duration _____

Due to Cerebral thromb

Due to undetermined

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

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN H. L.
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)
(b) Manner of injury _____

23. Signature Clifton Smith (M. D. or other) MD
Address 2603 Monterey St St Joseph Date signed 3/27/44

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(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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. Joseph

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.