

P. 2  
43  
7-39  
X36671

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 10 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10452

State File No. \_\_\_\_\_  
Registrar's No. 3808

Registration District No. 42 Primary Registration District No. 1000

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: St Joseph's Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 wks  
(Specify whether)

In this community 40 yrs  
years, months or days

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. 2608 S 13th  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country. \_\_\_\_\_

3. (a) PRINT FULL NAME Lucinda Johnson

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24  
year 1944 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from February 20  
1944 to March 24, 1944.

that I last saw her alive on March 23, 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 Widowed

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

7. Birth date of deceased: March 1, 1855  
(Month) (Day) (Year)

Immediate cause of death: Hypostatic pneumonia Duration 4 wks.

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

89 0 23 hr. \_\_\_\_\_ min.

Due to: Fractured hip 30 days

Due to: Fractured wrist 34 days

9. Birthplace: W. Va. 1  
(City, town, or county) (State or foreign country)

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

10. Usual occupation: House wife

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

12. Name: Roberts

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

14. Maiden name: ?

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

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant: Social Welfare Rec

(b) Address: St Joseph Mo

17. (a) Burial (b) Date thereof: 3-26-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: K. P. Cem. Trenton Mo

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

(b) Address: St Joseph, Mo

19. (a) 3-26-44 (b) Use St Joseph  
(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): Accident 131

(b) Date of occurrence: 2/20/44

(c) Where did injury occur? St. Joseph, Missouri  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place or public place?  
Home -- 2608 So. 13th  
(Specify type of place) (e) Means of injury: \_\_\_\_\_

23. Signature: W. M. - [Signature] (M. D. or other) \_\_\_\_\_  
Address: Social Welfare Board Date signed: 3/28/44

1233

(Licensed Embalmer's Statement on Reverse Side) 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.....

*Robert H. Yapple*

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.**