

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 14226  
 Registrar's No. 316

FILED MAY 11 1944  
 Registration District No. 42

Primary Registration District No. 1800

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 Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 day  
 (Specify whether  
 In this community 11 years  
 years, months or days)

3. (a) PRINT FULL NAME Bertha Zwolle

3. (b) If veteran, name war None  
 3. (c) Social Security No. None

4. Sex Female  
 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Gerad  
 6. (c) Age of husband or wife if alive 50 years  
 7. Birth date of deceased June 21, 1892  
 (Month) (Day) (Year)

8. AGE: Years 51 Months 9 Days 10  
 If less than one day hr. min.

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

10. Usual occupation Housewife  
 Home

11. Industry or business Home  
 12. Name Samuel Scowden  
 13. Birthplace Pike County, Ohio  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Phebe Jane Lowry  
 15. Birthplace California  
 (City, town, or county) (State or foreign country)

16. (a) Informant Gerad Zwolle (Husband)  
 (b) Address R.F.D. # 6, St. Joseph, Mo.

17. (a) Burial (b) Date thereof 4/3/44  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director John E. Gupp  
 (b) Address St. Joseph, Mo.

19. (a) 4/3/44 (b) Rose Heitz  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
 (c) City or town St. Joseph (Rural)  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. R.F.D. # 6  
 (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 31  
 year 1944 hour 11 minute 00 P.M.  
 21. I hereby certify that I attended the deceased from 18 44 July 31 19 44  
 that I last saw him alive on 18 44 July 31 19 44  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
 Ch. Coronary Heart Disease  
 acute Myocarditis  
 Angina Pectoris  
 Due to

Other conditions (Include pregnancy within 3 months of death)  
 94A

Major findings: Abnormalities in autopsy findings  
 Of autopsy

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)  
 23. Signature J. R. L. (M. D. or other)  
 Address 134 Del Ave Date signed 4/3/44

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

1233

St Joseph Mo

OCT 24 1958

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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, ~~only~~

working under my personal supervision. \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.