

FILED MAY 24 1944

Primary Registration District No. 1000

Registrar's No. 45-4

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:  
1304 South 17th. Street  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Not  
(Specify whether years, months or days)

In this community 50 years

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. 1304 South 17th. Street  
(If rural, give location)

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

3. (a) PRINT FULL NAME Josephine Colbert

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th.  
year 1944 hour 2:55 minute A. M.

21. I hereby certify that I attended the deceased from 4.14.44  
\_\_\_\_\_, 19\_\_\_\_, to 4.15.44 19\_\_\_\_;  
that I last saw her alive on 4.15.44 19\_\_\_\_;  
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 widow

6. (b) Name of husband or wife Andrew Colbert

6. (c) Age of husband or wife if alive 26 years 1860

7. Birth date of deceased: June (Month) 26 (Day) 1860 (Year)

Immediate cause of death Hypostatic pneumonia Duration 24hrs

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

<u>83</u>	<u>9</u>	<u>20</u>	hr. min.
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Due to Myocardial degeneration 1-1/2 yrs

9. Birthplace Louisville Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation Homr

Due to \_\_\_\_\_

Other conditions 0  
(Include pregnancy within 3 months of death)

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

12. Name James Boatwright

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

14. Maiden name Unknown

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

Major findings: Of operations 0

Of autopsy 0

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

MOTHER FATHER {

16. (a) Informant Mrs. Rebecca Borchardt

(b) Address 1304 So. 17th. St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Hatter Meierhoff

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

19. (a) 4/18/44 (Date received local registrar) (b) Rae Helwig (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 0

(b) Date of occurrence 0

(c) Where did injury occur? 0 (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 J. P. C. ... (M. D. or other) \_\_\_\_\_  
Address St. Joseph, Mo. Date signed 4.17.44

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

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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, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Albert C. Harrington*.....

Licensed Embalmer No. 3258 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.**