

FILED JUL 6 1944  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1420

State File No. \_\_\_\_\_

Registrar's No. 671

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: State Hosp. No 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 26 yrs 10 mos  
(Specify whether years, months or days) 26 yrs 10 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 11  
(c) City or town 1  
(If outside city or town limits, write "RURAL") 7  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME

Vivian Bancroft

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

4. Sex fem 5. Color or race wh 6. (a) Single, widowed, married divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased. 1887  
(Month) (Day) (Year)

8. AGE: Years 57 Months 2 Days 2 If less than one day hr. min.

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

10. Usual occupation Laundry

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

MOTHER FATHER

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 State Hosp Records  
(b) Address St. Joseph Mo  
17. (a) Burial (b) Date thereof 6-28-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation State Hosp #2

18. (a) Signature of funeral director Clark Hartney  
(b) Address \_\_\_\_\_

19. (a) 6/28/44 (b) Helen J. Pickle  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26  
year 1944 hour 5 minute 10 A.M.

21. I hereby certify that I attended the deceased from March 1, 1944 to June 26, 1944  
that I last saw her alive on June 26, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death intestinal obstruction  
hypostatic pneumonia Duration \_\_\_\_\_

Due to ptosis of colon  
Due to \_\_\_\_\_

Other conditions drug + alcohol psychosis  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy fatty degeneration of heart  
hypostatic pneumonia  
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 Doris Hochdorfer M.D. (M.D. or other)  
Address State Hosp. No 20 Date signed 6/28/44

*[Handwritten notes and scribbles at the top of the page, including "BOFF" and "11/11"]*

**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 not \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_ working under my personal supervision.

Signed *Emma Clark*

Licensed Embalmer No. 4238

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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. JulyRegistrar's No. 671Registration District No. 42Primary 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:

(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 days3. (a) PRINT  
FULL NAME Uwian Bancroft3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex F5. Color or  
race W6. (a) Single, widowed, married,  
divorced ✓

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if  
alive \_\_\_\_\_7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)8. AGE: Years 57 Months \_\_\_\_\_ 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) William J. P. Kelly  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Jackson(c) City or town Jackson City  
(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 June 26  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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

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

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 sta-  
tistically.

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

21052