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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21122

State File No.

FILED JUN 29 1944

Registrar's No. 630

Registration District No. 22

Primary Registration District No. 1000

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

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town Saint Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None 228 Iowa Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Whole life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan //
(c) City or town Saint Joseph //
(If outside city or town limits, write "RURAL") //
(d) Street No. 228 Iowa Ave. //
(If rural, give location) //
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Arzul⁸ Mc Nair

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec. 9th 1901
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
42 5 26 hr. 0 min.

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

10. Usual occupation House keeper

11. Industry or business None

MOTHER FATHER { 12. Name Richard Jones
13. Birthplace Buchanan County (City, town or county) (State or foreign country)
14. Maiden name Maggie Shelton
15. Birthplace Buchanan County (City, town, or county) (State or foreign country)

16. (a) Informant Richard Jones

(b) Address 228 Iowa Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/1944
(Month) (Day) (Year)

(c) Place: burial or cremation Burial Shiland

18. (a) Signature of funeral director Ramsey & Son Mort.

(b) Address I602 Messanie

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5th
year 1944 hour 7 minute 15 A.M.

21. I hereby certify that I attended the deceased from June 15 1944 to 19 1944
that I last saw viewed alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Coronary thrombosis
Due to 930

Other conditions Woman died during the night while in bed in her home. She has suffered with chronic degeneration for one year.
Major findings no Cardio-vascular
Of operations _____
Of autopsy _____

22. If death was due to external cause, 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 H. F. Mundy (M. D. or other) Coroner
Address 404 1/2 So 3d St Date signed 6/10/44

Duration 1 yr
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

1377

MAY 62 NDR

JUL 1 1962

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.....

R. F. Ramsey

....., Registered Apprentice No.

working under my personal supervision.

Signed *R. F. Ramsey*

Licensed Embalmer No. *4081*

P. O. Address *1602 Mission*

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.

Registration District No. *42* Primary Registration District No. *1000*

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

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 days
3. (a) PRINT FULL NAME *Argula McHair*
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *F* 5. Color or race *B* 6. (a) Single, widowed, married, divorced *w*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years *42* Months *5* Days *3* 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) *6/9/44* (b) *Nelen J. Pickle*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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* Year *1944* Minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; 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)

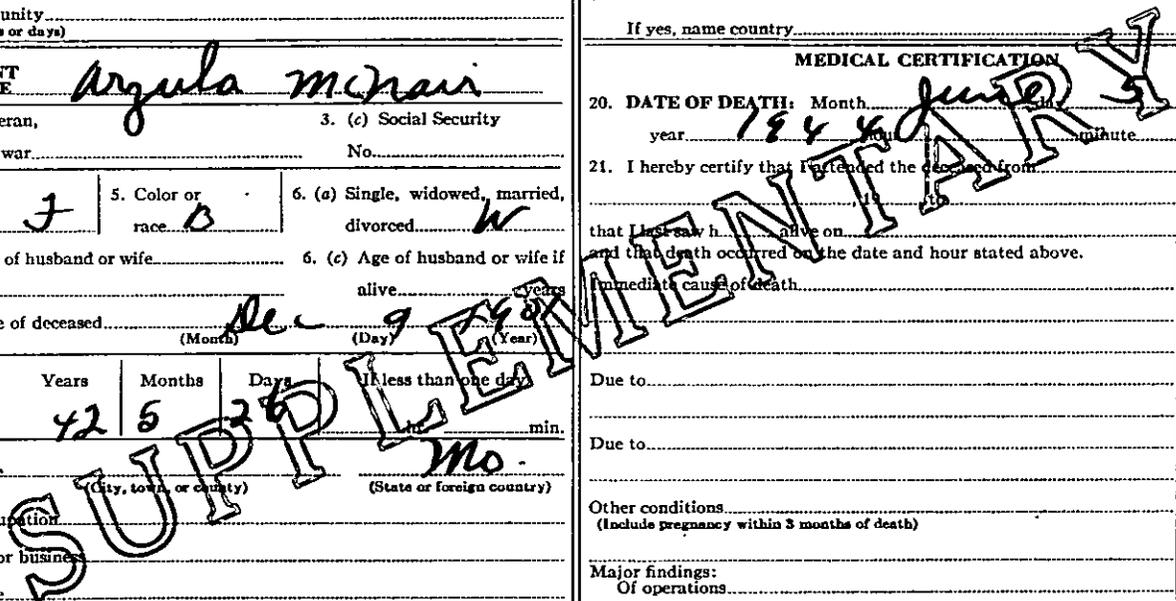
PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____



21122