21160

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 8 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 691

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 Hospital #2 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 24 yrs 10 mos 15 days (Specify whether
In this community yes
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town KC 11
(If outside city or town limits, write "RURAL") 1
(d) Street No. not given 7
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Edna Sperling

3. (b) If veteran, name war No

3. (c) Social Security No.

4. Sex Female

5. Color or race White 2

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife not given

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

7. Birth date of deceased About 1876. (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
68	x	x	hr. min.

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

10. Usual occupation Domestic

11. Industry or business at home

FATHER
12. Name Unknown.
13. Birthplace New York. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown.
15. Birthplace Unknown. Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Hospital 2 Record
(b) Address St Joseph Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26/44 (Month) (Day) (Year)
(c) Place: burial or cremation State Hospital #2

18. (a) Signature of funeral director Herman W. Sidenfaden
(b) Address 1802 Union St. St. Joseph Mo.

19. (a) 6/22/44 (Date received local registrar) (b) Helen J Fickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6/22 day
year 1944 hour 3 minute a M.

21. I hereby certify that I attended the deceased from Jan 1st 1944, to June 22, 1944
that I last saw her alive on June 21, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Rupture of heart muscles left ventricle weed suddenly

Due to aortic aneurism

Due to arteriosclerosis

Other conditions
(Include pregnancy within 3 months of death)

96

Major findings:
Of operations

Of autopsy: Rupture of heart muscles left ventricle

Duration

PHYSICIAN

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?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature [signature] (M.D. or other)
Address State Hospital #2 St Joseph Date signed 6/26/1944

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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERM[illegible]T RECORD

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 No Embalming, Registered Apprentice No. ..... working under my personal supervision.

Signed Herman Wm Sidenfaden

Licensed Embalmer No. 2728

P. O. Address St Joseph Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.