V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

24160

State File No.

FILED AUG 3 1944

Registration District No. 7 Primary Registration District No. 1600 Registrar's No. 773

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: 2125 So. 4th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 5 years (Specify whether years, months or days)
In this community: 38 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan 11
(c) City or town: St. Joseph 1
(If outside city or town limits, write "RURAL")
(d) Street No.: 2125 So. 4th St. 7
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Anna B. Sherwood
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: Female 1
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed 2
6. (b) Name of husband or wife: None
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: August (Month) 9, (Day) 1861 (Year)

8. AGE: Years 82 Months 11 Days 14 If less than one day hr. min.

9. Birthplace: DeTroit (City, town, or county) Michaigan (State or foreign country)
10. Usual occupation: Housekeeper
11. Industry or business: Home
FATHER 12. Name: Joseph Anderson
FATHER 13. Birthplace: Unknown (City, town, or county) U (State or foreign country)
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Unknown (City, town, or county) U (State or foreign country)
16. (a) Informant: Grace A. Roberts (Daughter)
(b) Address: 2213 So. 4th St., City
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7/25/44 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park Cemetery
18. (a) Signature of funeral director: John E. Kupp
(b) Address: 6054 Pryor Ave., City
19. (a) 7/25/44 (Date received local registrar) (b) Helen J. Pickel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23 year 1944 hour 8 minute 50 P.M.
21. I hereby certify that I attended the deceased from July 10, 1944, to July 23, 1944, that I last saw him alive on July 23, 1944, and that death occurred on the date and hour stated above.
Immediate cause of death: Pneumonia-Hypostatic 1 hr. 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 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:
23. Signature: Leroi Bock M.D. (M. D. or other)
Address: King Hill Ave. Date signed: 7/24/44
St Joseph Mo

1377 (Licensed Embalmer's Statement on Reverse Side)

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 John E. Rupp

Licensed Embalmer No. 3986

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.