DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 27 1944

Registration District No. _____

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33736

Primary Registration District No. 1000

Registrar's No. 1056

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: Mercy Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 70 hrs (Specify whether years, months or days)
In this community: same

2. USUAL RESIDENCE OF DECEASED:
(a) State: Kansas (b) County: Doniphan
(c) City or town: Elwood
(If outside city or town limits, write "RURAL")
(d) Street No.: None
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Emma Moskau
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Albert
6. (c) Age of husband or wife if alive: ____ years
7. Birth date of deceased: Sept. 14 (Month) 1869 (Day) (Year)

8. AGE: Years 75 | Months 1 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace: Washington (City, town, or county) Ind. 1 (State or foreign country)
10. Usual occupation: House wife
11. Industry or business:
MOTHER FATHER
12. Name: Wm Robbins
13. Birthplace: ? (City, town, or county) ? Ill (State or foreign country)
14. Maiden name: Emma
15. Birthplace: ? (City, town, or county) Ill (State or foreign country)
16. (a) Informant: Mrs L. C. Burr
(b) Address: Denver Col.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-23-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park Cem
18. (a) Signature of funeral director: Fleeman & Son Inc
(b) Address: St Joseph, Mo.
19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19 year 1944 hour 10 minute 45 P. M.
21. I hereby certify that I attended the deceased from Sept 19, 1944, to Oct 19, 1944, that I last saw her alive on Oct 19, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to: Pernicious Anemia	
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?
While at work? (Specify type of place) (e) Means of injury
23. Signature: Frank J. Blair (M. D. or other) MD
Address: Indy Kans Date signed 10/25/44

1377

(Licensed Embalmer's Statement on Reverse Side)

NOV 1 1944

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 Robert L Gaple

Licensed Embalmer No. 3308

P. O. Address St Joseph, M

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17 on

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1056

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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Emma Meskan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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 Sept 14 1859 (Month) (Day) (Year)

8. AGE: Years 75 Months 1 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 10/23/44 (Date received local registrar) (b) Helen S. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October Day 29 year 1944 hour 10 minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h 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 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH
(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution _____
(If not in hospital or institution, give street address or location)
(d) Length of stay: In hospital or institution _____ (days)
In this city _____ (days)

2. (a) PRINT FULL NAME _____
3. (b) Usual residence _____
Home No. _____

4. SEX _____
5. Color or race _____
6. (a) Married, widowed, divorced, or never married _____
6. (b) Name of husband or wife _____
7. Birthplace _____
8. Age _____

FEB 1 1945

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