

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

FILED NOV 6 1944
Registration District No. **1**

Primary Registration District No. **1000**

Registrar's No. **1090**

1. PLACE OF DEATH:

(a) County **Buehaway**

(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **706 Powell**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community **abt 10 yrs.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Buehaway**

(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)

(d) Street No. **706 Powell St**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MARY-I- NOLAND**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **220**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **1**
year **1944** hour **10** minute **20** M.

21. I hereby certify that I attended the deceased from **past year** to **11-1-1944**
that I last saw her alive on **10/31** 19**44**
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color of race **Wh**

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

6. (b) Name of husband or wife **Mattison C.**

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

7. Birth date of deceased **Apr 10 1860**
(Month) (Day) (Year)

Immediate cause of death **5 in city without dementia**

8. AGE:	Years	Months	Days	If less than one day
	84	6	21	hr. min.

Due to **83A'**

Due to _____

Other conditions **Cerebral hemorrhage**
(Include pregnancy within 3 months of death)

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

10. Usual occupation **at home**

Major findings:
Of operations _____

Of autopsy _____

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

11. Industry or business _____

MOTHER FATHER

12. Name **John W. Cunningham**

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

14. Maiden name **Margaret E. Cunningham**

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

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? _____

16. (a) Informant **Iva Noland**

(b) Address **706 Powell St.**

17. (a) _____ (b) Date thereof **11-4-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bourbon Mo**

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **T. H. Hedgpeth** (M. D. or other)
Address **Kirkpatrick Bldg** Date signed **11-3-44**

18. (a) Signature of funeral director **St. Joseph Funeral Home**

(b) Address **St. Joseph Mo**

19. (a) **11-4-44** (Date received local registrar)

(b) **Helene J. Dickel** (Registrar's signature)

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

Dr. H. J. Smith
Chicago, Ill.

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.