

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 119

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural, Prairie Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Jackson Co. Emery Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: in hospital or institution 7 weeks
(Specify whether years, months or days)

In this community 7 weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Independence, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 1506 S. Spring
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Lydia Jostameyer

3. (b) If veteran, name war no

3. (c) Social Security No. 271 20

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 3
year 1944 hour 8 minutes 30 P. M.

4. Sex Female 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 Mar. 2 1981
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 11, 1944 to Sept 3, 1944
that I last saw him alive on Nov 30, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Staccardia ✓

Duration _____

8. AGE: Years Months Days If less than one day

63 6 1 hr. _____ min.

Due to _____

Due to _____

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

10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name William Spree

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

14. Maiden name Unknown

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Emma F. Heat

(b) Address 1506 S. Spring, Ind.

17. (a) Removal (b) Date thereof Sept 9-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph, Mo.

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? _____

18. (a) Signature of funeral director J. M. Schuch

(b) Address Independence, Mo.

19. (a) Oct 9-1944 (b) J. M. Schuch
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury C

Signature J. W. Tuttle (M. D. or other) MO

Address Blue Springs, Mo. Date signed 9/2/44

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

MOTHER FATHER

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 Floyd C. Larson
Licensed Embalmer No. 4199
P. O. Address Independence, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. nov

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Rural Pemberton
(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 Lydia Jostmayer
 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 march 2 (Month) (Day) (Year)

8. AGE: Years 63 Months 6 Days _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

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

19. (a) _____ (b) _____
(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 Sept Day 19 Year 1944 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____ 19____;
 that I last saw him _____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death Staccocardia

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? _____

While at work? _____
(Specify type of place) (a) Means of injury
 23. Signature J. W. Tuttle (M. D. or other) MD
 Address Blue Springs, Mo Date signed 10/2/44

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

SUPPLEMENTARY

34400