

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **1134**

1. PLACE OF DEATH:

(a) County Burgess
 (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 No 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 29 yr 1 mo 5 da
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Bentley
 (c) City or town Darlington
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MINNIE RAYDON

MEDICAL CERTIFICATION

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month Nov day 3
year 1944 hour 3 minute 0 M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Single

21. I hereby certify that I attended the deceased from
10-31 1944 to 11-3 1944
that I last saw her alive on 11-3 1944
and that death occurred on the date and hour stated above.

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

Immediate cause of death Lobar Pneumonia
Duration _____

7. Birth date of deceased not given 1867
(Month) (Day) (Year)

Due to _____
Due to 108

8. AGE: Years 77 Months ? Days ? If less than one day _____ hr. _____ min.

Other conditions Manic Depression
(Include pregnancy within 3 months of death)

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

Major findings: _____

10. Usual occupation House Maid

11. Industry or business _____

12. Name not given

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

14. Maiden name not given

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

Of operations _____

Of autopsy Lobar Pneumonia

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

22. If death was due to external causes, fill in the following:

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4, 1944
(Month) (Day) (Year)

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Place: burial or cremation State Hospital # 2

(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 Herman J. S. S. S.
(b) Address 1802 Union St. St. Joseph, Mo.

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

19. (a) 11-4-44 (b) Helen J. Fisher
(Date received local registrar) (Registrar's signature)

23. Signature Helen J. Fisher (M. D. or other) _____
Address St Joseph Mo Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT 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.....
....., 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.