

FILED MAR 31 1945

State File No.

Registration District No. 22

Primary Registration District No. 100

Registrar's No. 305

1. PLACE OF BIRTH:

(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:
2615 Olive
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 25 yrs
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Florence Alderson

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 Single
6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Dec 10 1904
(Month) (Day) (Year)

8. AGE: Years 40 Months 3 Days 4 If less than one day hr. min.

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

10. Usual occupation none

11. Industry or business none

12. Name David Alderson

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

14. Maiden name Francis Hines

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

16. (a) Informant Minnie Alderson

(b) Address St Joseph, Mo.

17. (a) Burial (b) Date thereof 3-17-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bedford Iowa

18. (a) Signature of funeral director Flemon & Son Inc

(b) Address St Joseph Mo.

19. (a) 3-17-45 (b) Reinal Parker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2615 Olive
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 14
year 1945 hour 1 minute 8 P.M.

21. I hereby certify that I attended the deceased from was called to see her March 14, 1945 to — 19 —

that I last saw her alive on March 14 19 45
and that death occurred on the date and hour stated above.

Immediate cause of death: acute myocardial Duration 5 hrs

Due to —

Due to —

Other conditions (Include pregnancy within 3 months of death) None

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 Dr. Maynard D (M. D. or other) —

Address 2601 Remond St Date signed 3/18/45

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. Yaph

Licensed Embalmer No.

3308

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.