. S. No. 2
M—9-4-41
ev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9058

FILED MAR 22 1945

Registration District No. 42 — Primary Registration District No. 1000 — Registrar's No. 252

1. PLACE OF DEATH:

(a) County Buchanon

(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 #2 (If not in hospital or institution, write street number or location)

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

In this community 49 yrs 1 mo 1 day years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanon

(c) City or town St Joseph Mo (If outside city or town limits, write "RURAL")

(d) Street No. 24 20 So 6th Street (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Mary Cartzendorfner

3. (b) If veteran, name war Nil

3. (c) Social Security No. Nil

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 May (Month) 20 (Day) 1876 (Year)

8. AGE:

Years	Months	Days	If less than one day
68	9	13	..... hr. ..... min.

9. Birthplace Buchanon County (City, town, or county) Mo (State or foreign country)

10. Usual occupation Nil

11. Industry or business Nil

FATHER
12. Name Cartzendorfner
13. Birthplace Penn (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Emily McMullen
15. Birthplace Probably Ill (City, town, or county) (State or foreign country)

16. (a) Informant State Hospital #2 records

(b) Address St Joseph Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-45 (Month) (Day) (Year)

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

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

(b) Address St Joseph Mo

19. (a) 3-6-45 (Date received local registrar) (b) Helen I Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3-3 day ..... year 1945 hour 7 minute P M.

21. I hereby certify that I attended the deceased from Jan 1st 1945 to Mar 3 1945 that I last saw her alive on Mar 3 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia of both lungs and pernicious Anemia — Duration 1 wk 1 year

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) 108

Major findings:
Of operations .....

Of autopsy Yes as above mentioned

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 O E Cassius (M. D. or other)

Address State Hospital #2 Date signed 3/6 1945

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

not

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 K Gaple

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.