

FILED MAR 20 1945  
Registration District No. 1000

Primary Registration District No. 1000

Registrar's No. 229

1. PLACE OF DEATH:

(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: State Hosp. # 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days  
(Specify whether years, months or days) & 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan

(c) City or town St. Joseph 11  
(If outside city or town limits, write "RURAL")

(d) Street No. 406 So 15th 1  
(If rural, give location)

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

3. (a) PRINT FULL NAME Hazel Lewis Darrow

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27  
year 1945 hour 2 minute 20 P M.

21. I hereby certify that I attended the deceased from 2-9-45  
2-17 1945 to 2-17 1945  
that I last saw her alive on 2-17 1945  
and that death occurred on the date and hour stated above.

4. Sex 71 5. Color or race W

6. (a) Name of husband or wife Carl Darrow

6. (b) Age of husband or wife if alive 57 years

7. Birth date of deceased 2 11 1893  
(Month) (Day) (Year)

Immediate cause of death Broncho pneumonia few days

8. AGE: Years 52 Months 0 Days 16  
If less than one day hr. min.

Due to Hypostasis

Due to

Other conditions Diabetes  
(Includes pregnancy within 3 months of death)

9. Birthplace Chicago Ill 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Saleslady

PHYSICIAN

Major findings: Diabetes

Of operations

Of autopsy

Underline the cause to which death should be charged statistically.

11. Industry or business

12. Name Thomas Lewis

13. Birthplace Unknown Ill 1  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Burr

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

16. (a) Informant Hospital records

(b) Address St. Joseph Mission

17. (a) Burial (b) Date thereof 3-2-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Auburn Cemeter

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 1307 Farson St. Joseph Mo

19. (a) 3/2/45 (b) Robert O. Kelly  
(Date received local registrar) (Registrar's signature)

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 E H Magee (M. D. or other)

Address State Hosp #2 Date signed 2/27/45

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

11  
1  
7

**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 Albert P. Harrington

Licensed Embalmer No. 3258

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.**