

FILED APR 17 1945

State File No. \_\_\_\_\_

Registration District No. 42

Primary Registration District No. 1800

Registrar's No. 384

1. PLACE OF DEATH:

(a) County Beech Grove  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 5220 South 2nd  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community abt 57 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Beech Grove  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5220 South 2nd  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARY- COOK.

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color Wht 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife William 6. (c) Age of husband or wife if alive 2 years  
7. Birth date of deceased April 3 1867  
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 29 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Thomas Guilfoyle  
13. Birthplace Do not know (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace Mrs. Charity Cook Payne (City, town, or county) (State or foreign country)

16. (a) Informant 1304 W. 19th St. K.C. Mo  
(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation Mem. Park Cem.

18. (a) Signature of funeral director Thomas French

(b) Address St. Joseph, Mo

19. (a) 4-3-45 (b) W. E. French  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2  
year 1945 hour 12:30 minute 0 M.

21. I hereby certify that I attended the deceased from April 6, 1945 to April 2, 1945  
that I last saw her alive on April 1, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Cerebro sclerosis

Decubitus ulcer 3 mo.

Chronic myocarditis

Due to Senile dementia - due to Hypertensive arteriosclerotic cardiovascular disease

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

Major findings: Of operations \_\_\_\_\_

Of autopsy 97

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 E. J. Grant (M. D. or other) MA

Address St. Joseph, Mo Date signed 4-3-45

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 John Ray Slawey  
Licensed Embalmer No. 2435  
P. O. Address St Joseph

**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.**