S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 5 1945

Registration District No. 42

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12933

Primary Registration District No. 100

Registrar's No. 482

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: Saint Joseph,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Pennant Cafeteria, 619½ Felix Street
(If not in hospital or institution, write street number or location)

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

In this community: 20 years,

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Buchanan 11

(c) City or town: St. Joseph 1
(If outside city or town limits, write "RURAL")

(d) Street No.: 2623 State Street 7
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country: 0

3. (a) PRINT FULL NAME: Anna E. Stuber

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ✓

4. Sex: Female 1

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Jacob Stuber

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: October (Month) 29 (Day) 1867 (Year)

8. AGE: Years 77 | Months 6 | Days 3 | If less than one day: hr. min.

9. Birthplace: Buchanan County, (City, town, or county) Missouri, (State or foreign country) 0

10. Usual occupation: None

11. Industry or business:

MOTHER FATHER

12. Name: Peter Fankhauser

13. Birthplace: Unknown (City, town, or county) Switzerland (State or foreign country)

14. Maiden name: Katherine Geimann

15. Birthplace: Unknown (City, town, or county) Switzerland (State or foreign country)

16. (a) Informant: William A Fankhauser

(b) Address: W Rural #1, St. Joseph, Missouri.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5/4/1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Ashland Cemetery

18. (a) Signature of funeral director: Walter Meierhoffer

(b) Address: 1302 Faraon St. St. Joseph, Missouri.

19. (a) 5-4-45 (Date received local registrar) (b) Helen L Tickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd. year 1945 hour 12 minute Noon M.

21. I hereby certify that I ~~attended~~ viewed the deceased from 4-2, 1945, to, 19..; that I last saw viewed alive on, 19..; and that death occurred on the date and hour stated above.

Immediate cause of death: Milking at Innominate Eldery

Due to:

Due to:

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

Major findings:
Of operations: —

Of autopsy: 92h

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions	

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: B. W. Tadlock Coroner (M. D. or other)

Address: Lincoln Hill Bldg. Date signed: 5/2/45

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(Licensed Embalmer's Statement on Reverse Side)

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. Thomas A. Bowman

Licensed Embalmer No. 1710

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.