

FILED JUL 10 1945 1/2

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

Registration District No. \_\_\_\_\_

Primary Registration District No. 1000

Registrar's No. 707

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: Sisters Hosp.  
(If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution 6 days. (Specify whether years, months or days)

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carter 25

(c) City or town Cameron Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

3. (a) PRINT FULL NAME Suzie Brennan

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4  
year 1945 hour 3:20 P. minute \_\_\_\_\_ M.

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 no record  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 30, 1945, to July 4, 1945;  
that I last saw her alive on July 4, 1945,  
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Colon (sigmoid) with obstruction

Due to \_\_\_\_\_

Due to \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>-</u>	<u>-</u>	hr. _____ min. _____

Other conditions: Arthritis Deformans 25 yr  
(Include pregnancy within 3 months of death)

9. Birthplace: no record (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

10. Usual occupation: at home

Major findings: Carcinoma of sigmoid  
Of operation: 7-3-45

Of autopsy: Woe

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

12. Name Phillip Brennan

13. Birthplace: no record (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

14. Maiden name: no record

15. Birthplace: no record (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

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? \_\_\_\_\_

16. (a) Informant Sister Hosp.

(b) Address St. Joseph Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Cameron

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature S.P. Lewis MD (M. D. or other) \_\_\_\_\_  
Address St. Joseph, Mo. Date signed 7/5/45

18. (a) Signature of funeral director Poland Funeral Home

(b) Address Cameron, Mo.

19. (a) 7-6-45 (Date received local registrar) (b) Helen S. Fickler (Registrar's signature)

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 <sup>will be</sup> ~~was~~ embalmed by me, or by.....

..... Registered Apprentice No. ....

working under my personal supervision.

Signed.....

..... Licensee Embalmer No. *3960*

**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.**