. S. No. 2
DM—8-43
v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 13 1945

Registration District No. 42

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23447

Primary Registration District No. 1000

Registrar's No. 814

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: Mo. Methodist Hospt. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ~~Buchanan~~ Clinton 25
(c) City or town ~~St Joseph~~ Cameron 1
(If outside city or town limits, write "RURAL")
(d) Street No. ~~St Mo Methodist Hospt~~ 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary Lusetta Althouse

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female | 5. Color or race Wh. | 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 March (Month) 4 (Day) 1890 (Year)

8. AGE: Years	Months	Days	If less than one day
55	4	22	hr. min.

9. Birthplace Turney (City, town, or county) MO (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business Home

MOTHER FATHER

12. Name Charles H. Althouse.
13. Birthplace Lockport N.Y. (City, town, or county) (State or foreign country)
14. Maiden name Susan F. Firkins
15. Birthplace Galva (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Will A. Althouse.
(b) Address Cameron Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29-45 (Month) (Day) (Year)
(c) Place: burial or cremation Cameron Mo

18. (a) Signature of funeral director DeMoss Crunk
(b) Address Cameron Mo.

19. (a) 7-28-45 (Date received local registrar) (b) Nelene Pickell (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month July day 26
year 1945 hour 5 minute 550 P. M.

21. I hereby certify that I attended the deceased from July 21st, 1945, to July 26, 1945; that I last saw h[illegible] alive on July 26, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Renal insufficiency	3 day
Due to: Operation	
Due to: ~~(b)~~ Adipose Apron	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: Fatty apron. 3	
Of autopsy	

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 Paul Thompson (M. D. or other)
Address St Joseph Mo Date signed 7-27-45

1377. (Licensed Embalmer's Statement on Reverse Side)

AUG 20 1945

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 Leo Mac Grenk

Licensed Embalmer No. 2533

P. O. Address Cameron 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.