V. S. No. 2
0M—9-4-41
Rev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

26866

State File No.

FILED SEP 12 1945

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 939

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: Stat Hospital # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 28 da (Specify whether

In this community 12 yr 8 mo 1 da
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan 11

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

(d) Street No. St Charles Hotel 7
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 6

If yes, name country

3. (a) PRINT FULL NAME Ocxavia J Hanna

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced 3

6. (b) Name of husband or wife John Hanna

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

7. Birth date of deceased May 28 (Month) (Day) 1860 (Year)

8. AGE: Years 85 | Months 3 | Days 1 | If less than one day ___ hr. ___ min.

9. Birthplace Sullivan (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation None

11. Industry or business None

FATHER
12. Name Nat Germ
13. Birthplace " " (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name " "
15. Birthplace " " (City, town, or county) 9 (State or foreign country)

16. (a) Informant Anna B Mansfield

(b) Address 3419 Omega St Joseph

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 7, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Herman Wm Sidenladen

(b) Address 1802 Union St. St. Joseph, Mo

19. (a) Sept. 6, 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29 year 1945 hour 5:15 minute P M.

21. I hereby certify that I attended the deceased from Aug 1, 1945, to Aug 29, 1945 that I last saw her alive on Aug 29, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Liver

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration: Months

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 J. H. Higdon (M. D. or other) MD

Address By L. T. Shuck O.D. Date signed 8/29/45

1428

(Licensed Embalmer's Statement on Reverse Side) ST. JOSEPH

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 Ehner Thomas, Registered Apprentice No. ....., working under my personal supervision.

Signed Ehner Thomas

Licensed Embalmer No. 2640

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.