

FILED 272121945

Primary Registration District No. 1000

Registrar's No. 951

1. PLACE OF DEATH:

(a) County Chester

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

(c) Name of hospital or institution State Hospital #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 1/2 (Specify whether
10 days Yes years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Flanada City Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 1827 Bellview
(If rural, give location)

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

3. (a) PRINT FULL NAME Dalh Smith

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

20. DATE OF DEATH: Month 8 day 30
year 1945 hour 8/20 minute a M.

4. Sex Female 5. Color or race colored

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

6. (b) Name of husband or wife no information

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

7. Birth date of deceased _____
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1st, 1945, to 8/30, 1945
and that I last saw her alive on 8/29, 1945
and that death occurred on the date and hour stated above

8. AGE: Years About 70 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation None

Immediate cause of death Asphyxiated
Right pneumonia 3 days
right lung
Due to arteriosclerosis 4 years

11. Industry or business _____

12. Name Malace Clark

13. Birthplace unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Henrietta

15. Birthplace not given 0
(City, town, or county) (State or foreign country)

Due to _____

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

16. (a) Informant Joe Joe Pesal

(b) Address 2248 Lydia St Mo

17. (a) burial (b) Date thereof 9-7-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation State Hosp #2

Major findings: Of operations -

Of autopsy -

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

18. (a) Signature of funeral director Daniel Ray

(b) Address 1602 Madison

19. (a) 9-10-45 (b) Ray Matthews
(Date received local registrar) (Registrar's signature)

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? _____

While at work at home (Specify type of place)

(e) Means of injury _____

23. Signature O. G. Collins (M. D. or other) _____
Address State Hospital #2 Date signed 9/10/1945

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

OCT 16 1956

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.....

Embalmed
J. F. Ramsey
Licensed Embalmer No. *4081*

P. O. Address *1602 Melissa*

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.