. S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 4 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30135

Registration District No. 42 Primary Registration District No. 5134 Registrar's No. 1015

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Rural Washington Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Route # 6, St.Joseph /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none (Specify whether
In this community Lifetime
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan //

(c) City or town St. Joseph Mo. 0
(If outside city or town limits, write "RURAL")

(d) Street No. Rt #6 0
(If rural, give location)

(e) Citizen of foreign country? none 0 (Yes or No)

If yes, name country no

3. (a) PRINT FULL NAME KATE GASPER

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female/

5. Color or race White

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

6. (b) Name of husband or wife none

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

7. Birth date of deceased March (Month) 17, (Day) 1873 (Year)

8. AGE: Years 72 Months 7 Days 3 If less than one day hr. min.

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

10. Usual occupation Housewif e

11. Industry or business none

FATHER
12. Name Charles Gasper
13. Birthplace Ind. (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Margaret Minninger
15. Birthplace Mo. (City, town, or county) 0 (State or foreign country)

16. (a) Informant Mr. Charels Gasper

(b) Address Rt #6, St Joseph MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/45 (Month) (Day) (Year)

(c) Place: burial or cremation King Hill Cementery

18. (a) Signature of funeral director Rupp, Funeral Home

(b) Address 6054 Pryor St. Joseph Mo.

19. (a) 9-24-1945 (Date received local registrar) (b) A J Westlebuck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 20 day 1945
year 1945 hour 4 minute 30 p M.

21. I hereby certify that I attended the deceased from Sept 17 1945, to Sept 20, 1945
that I last saw her alive on Sept 20, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Mitral Insufficiency — Duration Do not know

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 926

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 0

23. Signature Fenton N. Goodall (M. D. or other)

Address 1091 W Mo ave Date signed 9/21-45

1428 (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 Mollie E. Sidenfaden Fox

Licensed Embalmer No. 4235

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.