

FILED OCT 4 1945

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

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1002

1. PLACE OF DEATH:

(a) County Bereaham  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 2507 St. Joseph Ave  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community about 25 yrs. (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Bereaham 11  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2507 St. Joseph Ave  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME NETTIE-MAY-THOMAS

3. (b) If veteran, name, war WW 3. (c) Social Security No. none

4. Sex Female 5. Color Wh 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife Benj. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Apr. 27 1864  
(Month) (Day) (Year)

8. AGE: Years 81 Months 4 Days 26 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation at home

11. Industry or business

12. Name Bess Powell  
13. Birthplace Ohio (City, town, or county) (State or foreign country)  
14. Maiden name Eliza Jones  
15. Birthplace Ohio (City, town, or county) (State or foreign country)

(a) Informant Evelyn Thomas

(b) Address St. Joseph Mo

17. (a) B (b) Date thereof 9-20-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph Cem

18. (a) Signature of funeral director Alvin J. Powell

(b) Address St. Joseph Mo

19. (a) 9-20-45 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18  
year 1945 hour 7:20 minute 0 M.

21. I hereby certify that I attended the deceased from 9-16-45  
1945 to 9-18 1945  
that I last saw her alive on 9-17 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
Duration \_\_\_\_\_

Due to Arteriosclerosis

Due to Hypertension

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: [Signature]

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence 9-18-45

(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? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address 218 W. 17th Date signed 9-18-45

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

MOTHER, FATHER

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

