V. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 33212

FILED OCT 24 1945

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1118

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. Meth. Hosp. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 WK (Specify whether years, months or days)
In this community 1 WK

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Andrew
(c) City or town Rosendale 0
(If outside city or town limits, write "RURAL")
(d) Street No. None
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Nettie E. Mead
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lonnie
6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased April (Month) 13 (Day) 1886 (Year)

8. AGE: Years 59 Months 6 Days 0 If less than one day hr. min.

9. Birthplace (City, town, or county) Missouri (State or foreign country)
10. Usual occupation House wife
11. Industry or business
FATHER 12. Name M. A. Wakefield
13. Birthplace (City, town, or county) Mo 0 (State or foreign country)
MOTHER 14. Maiden name Nannie Anderson
15. Birthplace (City, town, or county) Mo 0 (State or foreign country)
16. (a) Informant Lonnie Mead
(b) Address Rosendale Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-14-45 (Month) (Day) (Year)
(c) Place: burial or cremation Nebr. City Nebr
18. (a) Signature of funeral director Fleeman & Son Inc
(b) Address St Joseph Mo.
19. (a) Oct. 19, 1945 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 13 year 1945 hour 10 minute 25 P. M.
21. I hereby certify that I attended the deceased from Oct 3, 1945, to Oct 13, 1945, that I last saw her alive on Oct 13, 1945, and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Uremia | 8 da. |
| Due to: Suppression of urine | 8 da. |
| Due to: | |
| Other conditions (Include pregnancy within 3 months of death): | |
| Major findings: Of operations: Fibroids uterus. | |
| 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 H. D. Nearly (M. D. or other)
Address St Joseph Mo Date signed 10-14-45

1100 (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~~ .....

..... ~~Registered Apprentice No.~~ .....

working under my personal supervision.

Signed Robert L. Yapla

Licensed Embalmer No. 3308

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.**