V. S. No. 2
OM—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

State File No. 36619

FILED DEC 27 1945

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1232

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

(d) Length of stay: In hospital or institution 4 yrs 7 mos (Specify whether years, months or days) In this community 11 days 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Buchanan

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

(d) Street No. 720 No 23d St Joseph (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: Dora Beierle

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: Married

6. (b) Name of husband or wife: William Berarle

6. (c) Age of husband or wife if alive: Not stated years

7. Birth date of deceased: Nov (Month) 11 (Day) 1873 (Year)

8. AGE: Years 72 Months 0 Days 2 If less than one day hr. min.

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

10. Usual occupation: Housewife

11. Industry or business: at home

MOTHER FATHER

12. Name: Jones

13. Birthplace: U.S. (City, town, or county) (State or foreign country)

14. Maiden name: Mary Green

15. Birthplace: U.S. (City, town, or county) (State or foreign country)

16. (a) Informant: Austin Charles Beierle

(b) Address: 720 No 23d St City

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/15/1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Ashland Cemetery

18. (a) Signature of funeral director: Walter Meierhuffer

(b) Address: 1302 Faraon, St. Joseph, Missouri

19. (a) Nov. 20, 1945 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11/13 year 1945 hour 4:50 minute 2 A.M.

21. I hereby certify that I attended the deceased from Nov 8, 1945 to Nov 13, 1945 that I last saw her alive on Nov 12, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic lobar pneumonia — Duration: 3 days

Due to: Arteriosclerosis — a few yrs

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings:
Of operations: No
Of autopsy: No

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: C. E. Cossman (M. D. or other)

Address: State Hospital #2 Date signed: 11/3/1945

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(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 Albert R. Harrington

Licensed Embalmer No. 3265-8. Mo.

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.