

FILED DEC 27 1945
Registration District No. **42**

Primary Registration District No. **1000**

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

1. PLACE OF DEATH: **Buchanan**

(a) County **Saint Joseph**

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

(c) Name of hospital or institution: **Saint Joseph Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 week**
(Specify whether years, months or days)

In this community **All her Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**

(c) City or town **Saint Joseph**
(If outside city or town limits, write "RURAL")

(d) Street No. **717 Mt. Mora Road**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Mrs. Maude Ethel MINNIS**

3. (b) If veteran, name war

3. (c) Social Security No. **None**

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband **Elmer George Minnis**

6. (c) Age of husband **27** years

7. Birth date of deceased **March 12, 1881**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
64	8	6	hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Heaton**

13. Birthplace **Unknown England**
(City, town, or county) (State or foreign country)

14. Maiden name **Maude Unknown**

15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Elmer Earl Minnis**

(b) Address **717 Mt. Mora Road**

17. (a) **Burial** (b) Date thereof **Nov. 21, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ashland Cemetery**

18. (a) Signature of funeral director **Mrs. E. P. Sidenfaden**

(b) Address **602 South 10th Street**

19. (a) **Dec. 1-1945** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **18th**
year **1945** hour **4** minute **15 P. M.**

21. I hereby certify that I attended the deceased from **Nov. 11** 19**45** to **Nov. 18** 19**45**
that I last saw h. **4** alive on **Nov 18** 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumo-pneum** Duration **3 days**

Due to _____

Due to **925**

Other conditions **Myocardial Infarction** ?
(Include pregnancy within 3 months of death)

Major findings: **Impureness of gall bladder**
Cholelithiasis

Of autopsy **None**

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 **Frank S. Anderson** (M. D. or other) _____
Address **670 Marcell** Date signed **11/19/45**

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.