

FILED JAN 28 1946

Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 1427

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: St Joseph's Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days
(Specify whether
In this community 50 years
years, months or days)

3. (a) PRINT FULL NAME Anna B. Block

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 Widowed
6. (b) Name of husband or wife JAMES 6. (c) Age of husband or wife if alive --- years
7. Birth date of deceased Jan 22 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 0 If less than one day
hr. _____ min. _____

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Henry Milliken
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Maria Jenks
15. Birthplace Pleasant Plains Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Earl Block
(b) Address St Joseph, Mo.
17. (a) Burial (b) Date thereof 12-26-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ashland Cem.

18. (a) Signature of funeral director Fleeman & Son Inc
(b) Address St Joseph, Mo.

19. (a) Jan 2 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1513 So 17th
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22
year 1945 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from December 11 1945 to December 22 1945
that I last saw her alive on December 22 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocardial insufficiency unknown
Due to Chronic Hypertension
Due to Arteriosclerosis general

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

Major findings:
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 _____
(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) _____
(a) Signature [Signature] (M. D. or other) MD
Address St Joseph, Mo. Date signed 1/2/46

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 H. Gable

Licensed Embalmer No.

3308

P. O. Address

Dr Joseph, Nev.

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.