S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 8 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

40627

State File No.

Registration District No. 42 Primary Registration District No. 5134 Registrar's No. 1369

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Washington Twp Industrial City (Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution R7D #3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community over 25 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan

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

(d) Street No. R-F-D-#3
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME OCIE - B - ROWE

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Fem

5. Color or race Wht

6. (a) Single, widowed, married, divorced Wed

6. (b) Name of husband or wife Jesse D

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb 8 (Month) 1870 (Day) (Year)

8. AGE: Years 75 Months 10 Days 11 If less than one day hr. min.

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

10. Usual occupation Housewife - at home

11. Industry or business

FATHER
12. Name Solon Jones
13. Birthplace (Unk.) (City, town, or county) Unk (State or foreign country)

MOTHER
14. Maiden name Jane Bush
15. Birthplace — (City, town, or county) Ohio (State or foreign country)

16. (a) Informant Jessie D. Rowe
(b) Address R7D#3 St Joseph Mo

17. (a) B (Burial, cremation, or removal) (b) Date thereof 12/21/1945 (Month) (Day) (Year)
(c) Place: burial or cremation Ashland

18. (a) Signature of funeral director Stamer Funeral Home
(b) Address St Joseph Mo

19. (a) Dec 26 1945 (Date received local registrar) A J Nestaruck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19 year 1945 hour 8 minute a M.

21. I hereby certify that I attended the deceased from Jan 1/45 to Dec 19, 1945, to Dec. 19, 1945 that I last saw her alive on Dec 18, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Due to General Debility

Due to

Other conditions Mitral Insufficiency
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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

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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 J G Thompson (M. D. or other)
Address 825 Charles Date signed 12/20/45

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

FEB 18 1946

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 John Roy Stone

Licensed Embalmer No. 2435

P. O. Address St Joseph

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.