No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4645

FILED MAR 8 1946

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 244

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: 519 South 6th St
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none (Specify whether years, months or days)

In this community 30 years

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. 519 South 6th St
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Emma Kirkendall

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife Clem

6. (c) Age of husband or wife if alive 86 years

7. Birth date of deceased March 1 1861 (Month) (Day) (Year)

8. AGE: Years 84 Months 11 Days 18 If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business home

FATHER
12. Name Joseph Caster
13. Birthplace unk (City, town, or county) unk (State or foreign country)

MOTHER
14. Maiden name unk
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Clem Kirkendall
(b) Address 519 South 6th St, St. Joseph, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22.46 (Month) (Day) (Year)
(c) Place: burial or cremation Ashland Cemetery

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

19. (a) Feb 28-46 (Date received local registrar) (b) A J Mathews (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 19 year 1946 hour 9 minute A.M. M.

21. I hereby certify that I attended the deceased from 1-16-46, 19__, to 2-14-46, 19__; that I last saw her alive on 2-14-46, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Thrombosis	5-days
Due to Aortic Regirgitation	1-yr
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 92a
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 0

23. Signature Charles H. Werner (M. D. or other)
Address Kirkpatrick Bldg Date signed 2/21/46

(Licensed Embalmer's Statement on Reverse Side)

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

3669

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. Siebenfaden 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.