

FILED MAR 8 1946 STANDARD CERTIFICATE OF DEATH

State File No. **4666**

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **192**

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 Hospital**
(If not in hospital or institution, write street number and location)
 (d) Length of stay: In hospital or institution **20 days**
Specify whether
 In this community **Life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Buchanan**
 (c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3402 1/2**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **MARTHA - I. MIL BOURN**

3. (b) If veteran, name war **WW** 3. (c) Social Security No. **215**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
 6. (b) Name of husband or wife **Valentine** 6. (c) Age of husband or wife if alive **76** years
 7. Birth date of deceased **Nov 18 1862**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	83	2	24	hr. _____ min.

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

10. Usual occupation **at home**

11. Industry or business _____

MOTHER FATHER
 12. Name **Jane, Mary, Louise**
 13. Birthplace **Missouri**
(City, town, or county) (State or foreign country)
 14. Maiden name **Mary, Castle**
 15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Ruby Milbourn**

(b) Address **13 Snodgrass, Wm**

17. (a) (b) Date thereof **2-14-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **St. Joseph**

(b) Address **St. Joseph, Mo**

19. (a) **Feb. 14, 1946**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **12**
 year **1946** hour **3:40** minute **2** M.
 21. I hereby certify that I attended the deceased from **Jan 24**, 19**46**, to **Feb 12**, 19**46**
 that I last saw her alive on **Feb 18**, 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death
1. Cachexia **2 mo**
2. Ehr myocarditis **4 yr**

Due to **Secondary anemia** **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**
 Due to **Carcinoma, Cervix; Referred**
 Other conditions **Fracture Rt femur** **2 mo**
(Include pregnancy within 3 months of death)

Major findings: **Vitaminosis, Senility**
 Of operations _____
 Of autopsy **4/8**

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? _____ (a) Means of Injury _____
 (b) _____

23. Signature **M. E. Gruner** (M. D. or other) **0**
 Address **Kirkpatrick Bldg. St. Joseph** Date signed **2/14/46**

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

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 Stacey
Licensed Embalmer No. 24357
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.

M. E. GRIMES, M. D.

PHYSICIAN AND SURGEON

Office Phone 2-3819

Kirkpatrick Building, St. Joseph, Missouri

Res. Phone 2-5527

For _____

Date

3-15-46

Address _____

R health was not due to fracture of hip. This accident was contributory and no doubt was a great factor. Should you need supplemental completed under such circumstances, please return. Receipt
_____ M. D.

TAKE THIS

KINDER'S PRESCRIPTION SHOP
622 FRANCIS ST. PHONE 2-2426

U. S. Reg. No. _____

46066

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Mar
Registrar's No. 192

Registration District No. 42 Primary Registration District No. 1000

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Martha J. Milbourn

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Nov 18 (Month) (Day) (Year)

8. AGE: Years 83 Months 2 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATE FROM

20. DATE OF DEATH: Month Mar year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I felt saw _____ and that death occurred on the date and hour stated above. _____ immediate cause of death _____

Due to _____

Due to _____

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY 2

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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

4/6/66