. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8591

FILED APR 10 1946

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 318

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: State Hospital #2 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 years 1 month (Specify whether 26 days
In this community over 7 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan

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

(d) Street No. 2705 S. 22 St.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Jennie Montgomery

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife James W. Montgomery

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

7. Birth date of deceased Aug (Month) 22 (Day) 1869 (Year)

8. AGE: Years 76 Months 6 Days 23 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

FATHER
12. Name James Marn
13. Birthplace — — — (City, town, or county) Canada (State or foreign country)

MOTHER
14. Maiden name Elizabeth Dunnisch
15. Birthplace — — — (City, town, or county) Iowa (State or foreign country)

16. (a) Informant Record Hospital
(b) Address St Joseph Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-18-46 (Month) (Day) (Year)
(c) Place: burial or cremation Colloway, Nebr.

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

19. (a) Mar. 19, 1946 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mch day 15 year 1946 hour 7 minute 40 P M.

21. I hereby certify that I attended the deceased from 12-15-1945, 19 to 3-15-1946, 19 that I last saw her alive on 3-15-1946, 19 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma Rectum	4 months
Due to	
Due to	
Other conditions Senile Psychosis (Include pregnancy within 3 months of death)	7 years

Major findings:
Of operations
Of autopsy

46d

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 Kel. Senne (M. D. or other) MD
Address State Hosp #2 St. Joseph, Mo Date signed 3-15-46

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(Licensed Embalmer's Statement on Reverse Side)

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 L Yaple

Licensed Embalmer No. 3308

P. O. Address St Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.