

FILED MAY 9 1946

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 434

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Joseph's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 9-22-46 to 4-16-46
 In this community Y.P.S.
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Buchanan
 (c) City or town 2104 Washington Ave
 (If outside city or town limits, write "RURAL")
 (d) Street No. St. Joseph, Missouri
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Rosa Lena Holtzclaw
 (b) If veteran, name war _____
 (c) Social Security No. 496-24-620

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 16th
 year 1946 hour 6:00 P minute P.M.
 21. I hereby certify that I attended the deceased from October 8th
1945, to April 16th, 1946
 that I last saw her alive on April 16th, 1946
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife (Not stated) 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased December 17th 1891
 (Month) (Day) (Year)

Immediate cause of death Carcinoma of lung Duration 3-4 mo
 Due to Carcinoma left breast 2 yrs
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years 54 Months 3 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Bethany, Missouri (City, town or county) (State or foreign country)
 10. Usual occupation Sales Clerk
 11. Industry or business Montgomery Ward, K.C. Mo
 12. Name William Henry Blithroed
 13. Birthplace Pennsylvania (City, town, or county) (State or foreign country)
 14. Maiden name Mary Elizabeth Ward
 15. Birthplace Bethany, Missouri (City, town, or county) (State or foreign country)

Major findings: none **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**
 Of operations _____
 Of autopsy none
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Earl Kern
 (b) Address 2104 Washington Ave St. J. Mo
 17. (a) Burial (b) Date thereof April 18 - 1946
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Smithville, Missouri
 18. (a) Signature of funeral director Volous Funeral Home
 (b) Address Smithville, Mo.
 19. (a) April 17, 1946 (b) Self
 (Date received local registrar) (Registrar's signature)

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 J. H. [unclear] (M. D. or dentist)
 Address St. Joseph, Mo Date signed 4-16-46

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

MOTHER FATHER

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 L. A. McLowry

Licensed Embalmer No. 2903

P. O. Address Smithville, 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.

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(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

3. (a) PRINT FULL NAME Rosa L. Holtzman

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 wid

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Dec 17
(Month) (Day) (Year)

8. AGE: Years 54 Months 3 Days _____ If less than one day _____ hr. _____ min.

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

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

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

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 _____

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to carcinoma left breast

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

Major findings: _____

Of operations _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

11163 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

12252