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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 8 1946
STANDARD CERTIFICATE OF DEATH

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 501

Registration District No. 42 Primary Registration District No. 1000

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

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's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)
 In this community 40 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME JOSEPHINE MALETA
 3. (b) If veteran, name war None
 3. (c) Social Security No. None

4. Sex Female
 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (c) Age of husband or wife if alive 80 years
 7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
 about 76 ? ? hr. min.

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

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER {
 12. Name Unknown
 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 Stanley Maleta (Son)
 (b) Address St. Joseph Police Dept.

17. (a) Burial (b) Date thereof 4/30/46
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director [Signature]
 (b) Address 6054 Pryor Ave., City

19. (a) May 1, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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. 615 Alabama St.
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 28
 year 1946 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from 9-1-45 to 4-28-46
 that I last saw her alive on 4/28/46
 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage
 Due to: Hypertension
 Due to: Arteriosclerosis
 Other conditions: _____
(Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations: _____
 Of autopsy: _____

Duration 5 days
 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? _____

23. Signature [Signature]
 Address 418 1/2 St. Joseph Date signed 4/28/46

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, ~~only~~.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed John E. Rupp

Licensed Embalmer No. 3986

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.