

FILED MAY 6 1946
Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **511**

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 **2 Days**
(Specify whether years, months or days)
In this community **53 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. **2003 So. 11th. St.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country *****

3. (a) PRINT FULL NAME **Amelia Mary Verner**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **30**
year **1946** hour **4** minute **03** P. M.

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

21. I hereby certify that I attended the deceased from **Apr 28**, 19**46**, to **Apr 30**, 19**46**, that I last saw him alive on **Apr 30**, 19**46**, 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 **Married**
6. (b) Name of husband or wife **Robert F. Verner** 6. (c) Age of husband or wife if alive **75** years
7. Birth date of deceased **May** **13** **1872**
(Month) (Day) (Year)

Immediate cause of death **Cerebral Hemorrhage**
Duration **4/28/46**

8. AGE:	Years	Months	Days	If less than one day
	73	11	17	hr. min.

Due to **arterio scl. gen.**
Due to _____

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

Other conditions **Metal Stenosis**
(Include pregnancy within 3 months of death)

10. Usual occupation **Housewife**

11. Industry or business **None**

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

12. Name **Joseph Herynk**

13. Birthplace **Unknown** **Bohemia**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown** **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Robert F. Verner**

(b) Address **2003 So. 11th. St.**

17. (a) **Burial** (b) Date thereof **May 3, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olivet Cemetery**

18. (a) Signature of funeral director **Norman W. Anderson**

(b) Address **1802 Union St. St. Joseph, Mo.**

19. (a) **May 2, 1946** (b) **[Signature]**
(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 **Frank Anderson** (M. D. or other) _____
Address **620 Thence** Date signed **5/1/46**

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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 Elmer Thomas

Licensed Embalmer No. 2640

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.