

**FILED JUL 9 1946**

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 758

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:  
2232 South 6th. Street  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Not (Specify whether  
In this community 1 month  
years, months or days)

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. 2232 South 6th. Street  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Mrs. Cora Ellen DeCapito  
3. (b) If veteran, name war No 3. (c) Social Security No. None

20. DATE OF DEATH: Months June day 29th  
year 1946 hour 6 minute P. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife W. M. DeCapito 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased May 4 1869  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 27, 1946 to June 29, 1946  
that I last saw her alive on June 29, 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
77 1 25 hr. min.

Immediate cause of death  
Broncho-pneumonia  
Due to Bronchial asthma

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

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy 101

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name Wilson Boyd  
13. Birthplace Unknown Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Emerine Hill  
15. Birthplace Unknown Missouri  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Clarence E. Needham  
(b) Address 2232 So. 6th. St., St. Joseph, Missouri  
17. (a) Removal (b) Date thereof 6/29/1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation Excelsior Springs, Missouri  
18. (a) Signature of funeral director Thate Meierhoff  
(b) Address 1302 Faraon, St. Joseph, Missouri  
19. (a) July 2, 1946 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature Clarence E. Needham (M. D. or other) \_\_\_\_\_  
Address 825 Charles St. St. Joseph, Mo. Date signed 7/2/46

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

18330

JUN 16 1950

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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 *Walter Heurhopper Jr.*

Licensed Embalmer No. Missouri 4244

P. O. Address. St. Joseph, Missouri.

**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.