

No. 1-17-39  
X3671

**FILED AUG 9 1946**

Registration District No. **2**

Primary Registration District No. **5019**

Registrar's No. **82\***

1. PLACE OF DEATH:

(a) County **Andrew**

(b) City or town **Rochester**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**Rochester, Missouri**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **Life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Anna Belle Sigrist**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Female**

5. Color or race **white**

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive **1894** years

7. Birth date of deceased **October 16 1894**  
(Month) (Day) (Year)

8. AGE: Years **51** Months **9** Days **4**  
If less than one day hr. min.

9. Birthplace **Andrew County Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business **At Home**

12. Name **Charles Sigrist**

13. Birthplace **Andrew Co. Missouri**  
(City, town, or county) (State or foreign country)

14. Maiden name **Bettie Taylor**

15. Birthplace **Andrew Co. Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Edna Venard**

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

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **July 23/46**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Rochester Cemetery**

18. (a) Signature of funeral director **Heaton Bogale: Bowman**

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

19. (a) **7-24-46** (Date received local registrar) (b) **Lillian Sparks** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Andrew**

(c) City or town **Rochester**  
(If outside city or town limits, write "RURAL")

(d) Street No. **Rochester**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **20** year **1946** hour **11** minute **56** P. M.

21. I hereby certify that I attended the deceased from **Jan 5-42** to **July 20 1946**  
that I last saw her alive on **July 15 1946**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of breast (Removed)**

Due to **Cancer of breast (Removed)**

Duration **6 mos. 16 yrs. 1942**

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Enlarged glands (1942)**  
Of operations: **X Ray Breast**

Of autopsy: **No**

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

23. Signature **H. S. Soward** (M.D. or other) Address **St. Joseph, Mo.** Date signed **7-22-46**

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

MOTHER FATHER

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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.....  
working under my personal supervision.

Signed Eugene Wood  
Licensed Embalmer No. 5804  
P. O. Address 319 1/2 10th St Joseph

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.

Registration District No. 2 Primary Registration District No. 5019

1. PLACE OF DEATH:  
(a) County Andrew  
(b) City or town Rochester  
(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 Anna B. Sigrink  
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 3  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 16  
(Month) (Day) (Year)

8. AGE: Years 51 Months 9 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 \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
(Immediate cause of death) \_\_\_\_\_

Cancer Liver  
Duration \_\_\_\_\_

Due to Cancer Rt. Breast 10/16/46

Due to operated 1942

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 46h

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 H. S. Jansal (M. D. or other) \_\_\_\_\_  
Address St. Joseph's Date signed \_\_\_\_\_

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

SUPPLEMENTARY

22585