S. No. 2
I—9-4-41
. 5-17-39
I X29484

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

28449

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED SEP 16 1946

State File No. 29613

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 999

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: State Hosp # 2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 yrs 11 mo 30 da (Specify whether years, months or days)
In this community 2 yrs. 11 mo. 30 da.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon 11
(c) City or town La Plata (If outside city or town limits, write "RURAL") 1
(d) Street No. --- (If rural, give location) 7
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Frances C Miles

3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced wid. 2
6. (b) Name of husband or wife no information
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased ? (Month) ? (Day) 1850 (Year)

8. AGE: Years 96+ Months ? Days ? If less than one day hr. min.

9. Birthplace Randolph Co (City, town, or county) Mo 11 (State or foreign country)
10. Usual occupation House mfe
11. Industry or business

FATHER
12. Name E T Turner
13. Birthplace ------- (City, town, or county) Tenn 1 (State or foreign country)

MOTHER
14. Maiden name Martha Gates
15. Birthplace ------- (City, town, or county) Ky 1 (State or foreign country)

16. (a) Informant Mrs. Frank B. Christie
(b) Address La Plata Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/2/1946 (Month) (Day) (Year)
(c) Place: burial or cremation La Plata, Missouri.
18. (a) Signature of funeral director Walter Meierhoffer
(b) Address 1302 Faraon, St. Joseph, Missouri.
19. (a) Sept. 3, 1946 (Date received local registrar) (b) H J Nestlebush (Registrar's signature) By VKH

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2 year 1946 hour 5:20 a.m. minute M.
21. I hereby certify that I attended the deceased from Aug 1, 1946, to Sept 2, 1946; that I last saw her alive on Sept 1, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Embolus — Duration Instant
Due to Senility
Due to
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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature L S Shuck (M. D. or other)
Address State Hosp # 2 St. Joseph, Mo. Date signed 9/2/46

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(Licensed Embalmer's Statement on Reverse Side)

MAR 23 1954

OCT 9 1946

OCT 10 1946

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 Albert C. Harring

Licensed Embalmer No. 3255 M

P. O. Address 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.