

S. No. 2
M-5-43
7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 23 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29625**
Registrar's No. **1041**

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**
(c) Name of hospital or institution: **Missouri Methodist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: **1 day** (Specify whether
In this community **Lifetime** (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **MARIE PETRO**
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. (b) Name of husband or wife **John C.** 6. (c) Age of husband or wife if alive **50** years
7. Birth date of deceased **June 23, 1901**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
45 **2** **20** hr. min.

9. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **unk.** **unk.**
13. Birthplace **unk.** **unk.**
(City, town, or county) (State or foreign country)
14. Maiden name **unk.** **unk.**
15. Birthplace **unk.** **unk.**
(City, town, or county) (State or foreign country)

16. (a) Informant **John C. Petro (husband)**
(b) Address **5933 King Hill Ave., City**

17. (a) **Burial** (b) Date thereof **9/16/46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Olivet Cemetery**

18. (a) Signature of funeral director **John C. Petro**
(b) Address **6054 Pryor Ave., City**

19. (a) **Sept. 17, 1946** (b) **J. H. Nestor**
(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. **5933 King Hill Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month **Sept.** day **13**,
year **1946** hour **10** minute **30 P.M.**
21. I hereby certify that I attended the deceased from
Sept 12, 1946 to **Sept 13, 1946**
that I last saw her alive on **Sept 13, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Congestive Heart Failure** Duration **12 hrs.**
Due to **Profound Anemia; type not determinable.** **2-3 mon.**
Due to

Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations **93E**
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
23. Signature **Robert H. Conrad** (M. D. or other) **M.D.**
Address **St. Joseph, Mo.** Date signed **Sept 14, 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.....

John E. Rupp
.....
Licensed Embalmer No. *7986*
.....
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.