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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 10 1947
Registration District No. 42

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 248
Registrar's No. 151

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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital (Osteopathic)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months (Specify whether years, months or days)
In this community 2 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. RR #1 Faucett, Mo.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Phebe Isaacs
3. (b) If veteran, name war None
3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 29,
year 1947, hour 11 minute 40 A.M.
21. I hereby certify that I attended the deceased from Dec 20, 1946 to JAN - 9, 1947
that I last saw her alive on JAN 29, 1947
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 George W. Isaacs
6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased February 2, 1875
(Month) (Day) (Year)

Immediate cause of death Hypostatic PNEUMONIA Duration 3 Day
Due to CARCINOMA of Pelvis ?

8. AGE: Years 71 Months 11 Days 27
If less than one day hr. min.

Due to _____
Other conditions (Include pregnancy within 3 months of death) 55E
Major findings: Of operations _____
Of autopsy _____

9. Birthplace Buchanan County Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business At home
12. Name D.L. McDaniel
13. Birthplace Platt County Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Martha Moore
15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant George W. Isaacs
(b) Address RR #1 Faucett, Missouri
17. (a) Burial (b) Date thereof 2/1/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Faucett Cemetery
18. (a) Signature of funeral director Walter Meierhoffer
(b) Address 1946 Colhoun St., St. Joseph, Mo.
19. (a) 2-4-47 (b) H. G. Jenkins
(Date received local registrar) (Registrar's signature)

23. Signature Clifford J. Steidley (M.D. or other) MD
Address Logan Bldg St. Joseph Date signed 1/30/47

18-7

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 *Robert R. Harrington*.....

Licensed Embalmer No. 3258 Missouri.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *248*

Registration District No. _____

Primary Registration District No. _____

Registrar's No. *151*

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:

(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 *Phoebe Isaacs*

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

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days _____ (If less than one day _____ 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 _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

(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 *Jan* Day _____
 year *1947* Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.
 Immediate cause of death _____ Duration _____

- Due to
- Cancer of Pelvis*

- Due to
- Cervix - uterus Wall of vagina*
- ?

Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____Of autopsy *48B*

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 _____ (M. D. or other)

Address _____ Date signed _____

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

S-248