

S. No. 2
-12-45
5-17-39
PI X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 254
Registrar's No. 22

FILED JAN 20 1947

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

(c) Name of hospital or institution:
2809 South 22nd
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 30 years 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. 2809 South 22nd
(If rural, give location)

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

3. (a) PRINT FULL NAME Elizabeth Ann Kuhn

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 widow

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

7. Birth date of deceased January 7 1367
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>79</u>	<u>11</u>	<u>23</u>	hr. min.

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

10. Usual occupation at home

11. Industry or business At home

MOTHER FATHER

12. Name Wm. B. Graves

13. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Sarah C. Gray

15. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clarence V. Hill

(b) Address St. Joseph, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 1/3/47
(Month) (Day) (Year)

(c) Place: burial or cremation Swinford Cemetery

18. (a) Signature of funeral director Heater Beale & Bowman

(b) Address St. Joseph, Mo.

19. (a) 1-8-47 (Date received local registrar) (b) E. L. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 5th
year 1947 hour 10 minute 55 P.M.

21. I hereby certify that I attended the deceased from 10-11-45
_____, 19____, to 1-4, 1947
that I last saw her alive on 1-5, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
myocardial infarction 2da
chronic myocarditis 3 yrs
senility 10 yrs

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Duration

2da

3 yrs

10 yrs

PHYSICIAN

Major findings:
Of operations 9319

Of autopsy _____

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 W. M. Trenchard (M. D. or other)
Address W. M. Trenchard M.D. (If signed)

JAN 29 1947

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 *Raymond W. Morhead*.....

Licensed Embalmer No. *4413 A*.....

P. O. Address *319 So 10th St*.....

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.