

DEPARTMENT OF COMMERCE
BUREAU OF HEALTH
FILED JAN 25 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 85

Registration District No. 42

Primary Registration District No. 1000

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:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Days (Hosp't.)
(Specify whether years, months or days)

In this community Lifetime

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. 210 No. 8th. St.
(If rural, give location)

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

3. (a) PRINT FULL NAME Anna M. "Foster" Neidinger

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 B. Neidinger

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased October 14 1867
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>79</u>	<u>3</u>	<u>0</u>	hr. _____ min. _____

9. Birthplace Sparks Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

12. Name James Browning

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

14. Maiden name Unknown

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

16. (a) Informant Mr. John B. Neidinger

(b) Address 210 No. 8th. St.

17. (a) Burial (b) Date thereof Jan. 16, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Norman W. Sidenfaden

(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) 1-21-47 (b) E. C. Jenkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14
year 1947 hour 7 minute 40 A. M.

21. I hereby certify that I attended the deceased from January 8, 1947 to January 14, 1947
and that death occurred on the date and hour stated above.

that I last saw her alive on January 13, 1947

Immediate cause of death: Septicemia
Chronic Myocarditis
Chronic Cholecystitis
Lithiasis
Obesity

Due to Acute Splenitis

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations 126

Of autopsy Suppurative Splenitis

Duration 4 days
undet
undet
undet
3-4 days

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 0

23. Signature Maxwell Day (M. D. or other) _____

Address 218 N. 7th St. St. Joseph Date signed 1-15-47

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

MS SEP 17 1955

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 Emmanuel Thomas

Licensed Embalmer No. 2640

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.