

S. No. 2
M-5-43
3-17-39
X36671

FILED MAR 14 1947

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 292

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:
2815 So. 19th Street /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 28 years. years, months or days)

3. (a) PRINT FULL NAME Sarah Vina Embrey

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 Divorced

6. (b) Name of husband or wife John F. Embrey

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased September 22 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

<u>77</u>	<u>5</u>	<u>9</u>	hr. min.
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9. Birthplace Ray County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

MOTHER FATHER

12. Name William D. Clark

13. Birthplace Unknown Unknown
(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 Sarland Embrey

(b) Address 1606 Spring St., St. Joseph, Mo.

17. (a) Burial (b) Date thereof Mar 3, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wynona Park Cem.

18. (a) Signature of funeral director Hattie Mierhoffer

(b) Address 1946 Colhoun St., St. Joseph, Mo.

19. (a) March 4, 1947 (b) G. L. Jenkins
(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. 2815 So. 19th Street
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1
year 1947 hour 3 minute 40 A. M.

21. I hereby certify that I attended the deceased from Feb 26, 1947 to March 1, 1947
that I last saw her or alive on Feb 28, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Leukemia

Due to _____

Due to _____

Duration
3 days

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

Major findings:
Of operations _____
Of autopsy 109A

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 J. Elliott (M. D. or other)
Address 8015 Francis St., St. Joseph, Mo. Date signed 3/1/47

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

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 E. 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.

Registration District No. A 2

Primary Registration District No. 1000

Registrar's No. 292

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

Sarah V. Embrey

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife.....

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

7. Birth date of deceased Sept 22 1870

(Month)

(Day)

(Year)

8. AGE:

Years 77

Months 5

Days

If less than one day

or min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

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)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(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. 2815 W. 19th. St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March
year 1947 hour 12 minute A M.
21. I hereby certify that I attended the deceased from Feb. 25 1947 to Feb. 28 1947
that I last saw him alive on Feb. 28, 1947
and that death occurred on the date and hour stated above.
Immediate cause of death Mitral Insufficiency Duration 3 yrs.

Due to Influenza 3 days

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature J. R. Elliott (M. D. or other) M. D.

Address 802 Francis St. St. Joseph Date filed 3/18/47

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

SUPPLEMENTAL

S-3984

Shyheim

8 0/2 Anas

J-R Elliott