

S. No. 2  
DOM-5-43  
ev. 5-17-39  
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DEPARTMENT OF HEALTH  
BUREAU OF THE CENSUS

UNITED STATES OF AMERICA  
STANDARD CERTIFICATE OF DEATH

8037

State File No. \_\_\_\_\_

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 354

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:  
109 E. Vassar  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10 days  
(Specify whether years, months or days)  
 In this community Most of life

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. 109 E. Vassar  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Flora C. Threlkeld  
 3. (b) If veteran, name war None  
 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month March day 10,  
 year 1947 hour 8 minute 00 A. M.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Benjamin  
 6. (c) Age of husband or wife if alive 75 years  
 7. Birth date of deceased July 4, 1875  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Mar 4, 1947, to Mar 10, 1947.  
 that I last saw her alive on March 9, 1947, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>71</u>	<u>7</u>	<u>6</u>	_____ hr. _____ min.

Immediate cause of death Cardiac Insufficiency Duration 14 months  
 Due to Streptococci sore throat 14 months ago.  
 Due to Had Influenza which started March 5, 1947 - caused massive strain on heart  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace Halifax, Nova Scotia 2  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Housewife

PHYSICIAN  
 Major findings:  
 Of operations 33B  
 Of autopsy \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

11. Industry or business Home  
 12. Name Charles Housemen  
 13. Birthplace Halifax, Nova Scotia  
 14. Maiden name Cecelia, Barnstead  
 15. Birthplace Halifax Nova Scotia 2  
(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? 2

16. (a) Informant Benjamin Threlkeld  
 (b) Address 109 E. Vassar St., City  
 17. (a) Burial 3/13/47  
(Burial, cremation, or removal) (Date thereof) (Month) (Day) (Year)  
 (c) Place: burial or cremation Memorial Park Cemetery

While at work \_\_\_\_\_ (Specify type of place)  
 (c) Means of injury \_\_\_\_\_  
 23. Signature Edith Gross (M. D. or other) OO  
 Address 5008 Spring Hill Date signed 3-8-47

18. (a) Signature of funeral director John B. Jenkins  
 (b) Address 6054 Pryor Ave., City  
 19. (a) 3-13-47 (b) h. h. Jenkins  
(Date received local registrar) (Registrar's signature)

382 (Licensed Embalmer's Statement on Reverse Side) St. Joseph, Mo

**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~~ .....

*Roland D. Clark*

Registered Apprentice No. *530*

working under my personal supervision.

Signed.....

*John E. Rupp*

Licensed Embalmer No. *3986*

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.**