

FILED OCT 13 1947

Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 1198

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

(d) Length of stay: In hospital or institution on arrival
(Specify whether in this community years, months or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Buchanan

(c) City or town St Joseph (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. R 7 B # 3 (Rural)
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME JENNIE S DINWIDDIE

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex Female 5. Color or race White

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

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Jan 6 1897
(Month) (Day) (Year)

8. AGE: Years 50 Months 8 Days 28
If less than one day hr. min.

9. Birthplace St Joseph Mo
(City, town, or county) (State or foreign country)

10. Usual occupation at home

MOTHER FATHER

11. Industry or business _____

12. Name William Rush

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

14. Maiden name Agnes Land

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

16. (a) Informant Paul Kennedy

(b) Address 3106 Penn St

17. (a) B (b) Date thereof 10-7-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director St Joseph Funeral Home

(b) Address St Joseph MO

19. (a) 10-9-47 (b) C. C. Jenkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6
year 1947 hour 10:30 minute P M.

21. I hereby certify that I attended the deceased from Oct 4, 1947, to Oct 6, 1947
that I last saw her alive on October 4, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral haemorrhage

Due to arterio sclerosis

Due to _____

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

Major findings: gibb

Of operations _____

Of autopsy ✓

Duration _____

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 A

23. Signature Colles Corcoran (M. D. or other) _____
Address Transpenn Rd Date signed Oct 6 47

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

Dr. Rowland

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.....

Charles M. Harman, Registered Apprentice No. 450
working under my personal supervision.

Signed John Roy Stoney

Licensed Embalmer No. 2435

P. O. Address St. Joseph

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.