

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

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St Joseph Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: State Hospital No 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20 days
 (Specify whether years, months or days) 25 years.

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Buchanan
 (c) City or town St Joseph
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4230 N. Noyes
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Bertha L. Markt
 3. (b) If veteran, name war None
 3. (c) Social Security No. None
 4. Sex F 5. Color or race W
 6. (a) Single, widowed, married, divorced Mar
 6. (b) Name of husband or wife Albert Markt
 6. (c) Age of husband or wife if alive 76 years
 7. Birth date of deceased Oct 30 1871
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept day 26
 year 1947 hour 12-32 minute P M.
 21. I hereby certify that I attended the deceased from 9-6-47
 _____, 19____, to 9-26, 1947;
 that I last saw him alive on 9-26, 1947;
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<u>J</u>	<u>75</u>	<u>10</u>	<u>26</u>	_____ hr. _____ min.

Immediate cause of death
myocardial degeneration
arteriosclerosis
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

MOTHER, FATHER

11. Industry or business _____
 12. Name John Stevenson
 13. Birthplace Oregon Mo
 (City, town, or county) (State or foreign country)
 14. Maiden name Bertha
 15. Birthplace Oregon Mo
 (City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Reverend Hospital
 (b) Address St Joseph Mo
 17. (a) Removal (b) Date thereof Sept. 30, 1947
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Oregon, Mo. Maple Grove Cem.
 18. (a) Signature of funeral director Walter Meierhoffer
 (b) Address 1946 Colhoun St., St. Joseph, Mo.
 19. (a) 10-1-47 (b) E. E. Jenkins
 (Date received local registrar) (Registrar's signature)

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? _____
 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature E. E. Salver (M. D. _____)
 Address St Joseph Mo Date signed 9-26-47

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SEP 2

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 Mo

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.