

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

FILED NOV 17 1947

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **1345**

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:  
**317 Albemarle St.**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1** (Specify whether)

In this community **48 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan** **11**

(c) City or town **St. Joseph** **1**  
(If outside city or town limits, write "RURAL")

(d) Street No. **317 Albemarle St.** **7**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **Nora E. Dawson**

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 **Widow**

6. (b) Name of husband or wife **Charles Dawson**

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

7. Birth date of deceased **July 31, 1873**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **17**  
year **1947** hour **10** minute **00** P.M.

21. I hereby certify that I attended the deceased from **5-20-46**  
19 **9-14-47** to **9-14-47** 19 **9-14-47**  
that I last saw **or** alive on **9-14-47** 19 **9-14-47**  
and that death occurred on the date and hour stated above.

8. AGE: Years **74** Months **2** Days **16** If less than one day **hr. min.**

9. Birthplace **Lexington, Ohio**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Own home**

Immediate cause of death

Due to **Coronary Arteriosclerosis & Pts.** **4 months** **Duration**

Due to **Coronary Insufficiency** **4 yrs.**

Other conditions (Include pregnancy within 3 months of death)

MOTHER FATHER

12. Name **William Smith**

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

14. Maiden name **Elizabeth Shauck**

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

16. (a) Informant **Eva Dawson**

(b) Address **317 Albemarle St.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Oct. 20, 1947**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Auburn Cemetery**

18. (a) Signature of funeral director **E. C. Clark**

(b) Address **5025 King Hill Ave.**

19. (a) **11-13-47** (Date received local registrar) (b) **G. L. Jenkins** (Registrar's signature)

PHYSICIAN

Major findings:  
Of operations **94A**

Of autopsy

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 **Floyd H. Jenkins** (M. D. or other) **0**  
Address **Residential Bldg.** Date signed **10-17-47**

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

NOV 19 1947

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.....

**Max E. Meyer**

Registered Apprentice No. **49**

working under my personal supervision.

Signed

*Emil Clark*

Licensed Embalmer No.

**4238**

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.**