

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

337

State File No. ....

Registrar's No. .... 41

Registration District No. .... 42

Primary Registration District No. .... 1000

## 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 Mo. Meth. Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days (Specify whether  
In this community 1 1/2 years years, months or days)

## 3. (a) PRINT

FULL NAME Stella Zeiber

## 3. (b) If veteran,

name war No

## 3. (c) Social Security No.

490-30-5636

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Harry Zeiber 6. (c) Age of husband or wife if alive 38 years  
7. Birth date of deceased October 26 1911  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>1</u>	<u>36</u>	<u>23</u>	<u>13</u>	hr. min.

9. Birthplace Richmond Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation At home11. Industry or business At home12. Name I. G. Tracy13. Birthplace Unknown Missouri  
(City, town, or county) (State or foreign country)14. Maiden name Sarah Martin15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)16. (a) Informant Harry Zeiber(b) Address St. Joseph, Mo.17. (a) Burial (b) Date thereof 1/12/48  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Memorial Park18. (a) Signature of funeral director Heaton-Bowman(b) Address St. Joseph, Mo.19. (a) 1-14-48 (b) E. B. 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. 612 Locust  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country .....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 9  
year 1948 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from Jan 8 1948 to Jan 9 1948  
that I last saw him alive on Jan 9 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of UterusDuration Unknown

Due to .....

Due to .....

Other conditions 48-B  
(Include pregnancy within 3 months of death)Major findings: 48-B

Of operations .....

Of autopsy .....

## PHYSICIAN

Underline the cause of 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? .....

(Specify type of place)

While at work? (e) Means of injury .....

23. Signature Maxwell Day (M. D. or other) .....Address 218 N. 7th St. Joseph, Mo. Date signed 1-9-48

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.....

William Spickard..... Registered Apprentice No. 28  
working under my personal supervision.

Signed.....

Eugene Wood  
Licensed Embalmer No. 3804

P. O. Address 3115 1st St. 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.