

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **25510**

FILED SEP 7 1948  
Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **919**

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:  
**415 North 7th, Street**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: **39 years**  
(Specify whether years, months or days)

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.: **415 North 7th, St.**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country:

3. (a) PRINT FULL NAME: **Lena Caroline McCombs**

3. (b) If veteran, name war: **No**  
3. (c) Social Security No.: **191-28-5293**

4. Sex: **Female** 5. Color or race: **White**  
6. (a) Single, widowed, married, divorced: **Divorced**  
6. (b) Name of husband or wife: **Earl McCombs**  
6. (c) Age of husband or wife if alive: **64** years  
7. Birth date of deceased: **June 26, 1886**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<b>62</b>	<b>1</b>	<b>29</b>	hr. min.

9. Birthplace: **Andrew County Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation: **At Home**

11. Industry or business: **William F. Jones**

12. Name: **Andrew County, Missouri**  
13. Birthplace: **Missouri**  
(City, town, or county) (State or foreign country)

14. Maiden name: **Rachel Poff**  
15. Birthplace: **Ohio**  
(City, town, or county) (State or foreign country)

16. (a) Informant: **Miss Bertha Jones**  
(b) Address: **415 No. 7th, St. Joseph, Mo.**

17. (a) **Burial** (b) Date thereof: **8-28-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation: **Ashland Cemetery**

18. (a) Signature of funeral director: **Funeral Home**  
(b) Address: **St. Joseph, Missouri**

19. (a) **9-2-48** (b) **H. B. Jenkins**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: **August** day: **25**  
year: **1948** hour: **4** minute: **00** P. M.

21. I hereby certify that I attended the deceased from **June 6, 1948** to **Aug 25, 1948**  
that I last saw **her** alive on **Aug 25, 1948**  
and that death occurred on the date and hour stated above.

Immediate cause of death:  
**Pulmonary Edema**  
**Chronic Myocarditis**

Duration

**8 hrs**

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

Major findings:  
Of operations: **93%**  
Of autops:

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?

While at work: (Specify type of place)  
(c) Means of injury:  
23. Signature: **Dr. A. Van Dine** (M. D.) or other: **Dr. D.**  
Address: **823 Farnon, St. Joseph, Mo. 64501**

MOTHER FATHER

8-27-48

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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Charles M. Harman*

Licensed Embalmer No. *4487*

P. O. Address: *St. Joseph*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.