

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **28924**

National Office of Vital Statistics

FILED SEP 27 1948  
Registration District No. **1000**

Primary Registration District No. **1000**

Registrar's No. **1006**

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: State Hospital No 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 54 yr 9 mo 16 day  
(Specify whether years, months or days)  
In this community 54 yr 9 mo 16 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Platte **83**  
(c) City or town Rural **0**  
(If outside city or town limits, write "RURAL") **0**  
(d) Street No. --  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No) **1**  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary J. Hale

3. (b) If veteran, name war --- 3. (c) Social Security No. ---

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive unk. years  
7. Birth date of deceased unknown  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>about 72</u>	<u>?</u>	<u>?</u>	.....hr. ....min.

9. Birthplace --- Mo **0**  
(City, town, or county) (State or foreign country)

10. Usual occupation House work

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name unknown **9**  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) **1**  
14. Maiden name unknown **9**  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. George E. Yersin  
(b) Address Pasadena leafy  
Med. School  
17. (a) Kirkville Schopl of Osteopathy (b) Date thereof 9/23/48  
(Date, location or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director John C. Rupp  
(b) Address 6054 Bryor Ave. City  
19. (a) Sept 25, 1948 (b) E. C. Jenkins  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 21  
year 1948 hour 5 minute A. M.  
21. I hereby certify that I attended the deceased from Sept 1  
1, 1948, to Sept 21, 1948,  
that I last saw her alive on Sept 20, 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
Due to Arteriosclerosis

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations 738  
Of autopsy \_\_\_\_\_

Duration

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 \_\_\_\_\_ **0**  
23. Signature Garnett Thomas (M. D. or other) **0**  
Address St Joseph Mo Date signed 9/21 48

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

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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~~ .....  
.....  
working under my personal supervision.

Signed..... *John E. Rupp*  
Registered Apprentice No.....  
Licensed Embalmer No. *3986*  
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.