

FILED SEP 27 1948

Registration District No. **172** Primary Registration District No. **1000** Registrar's No. **1004**

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: **Sisters Hospital**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **few minutes**
(Specify whether Life years, months or days)

3. (a) PRINT FULL NAME **Rose Ann Herbold**
 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 **Widowed**
 6. (b) Name of husband or wife **Alfred E. Herbold**
 6. (c) Age of husband or wife if alive **years**
 7. Birth date of deceased **March 21 1975**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 5 29 hr. min.

9. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **At home**

11. Industry or business **At home**

12. Name **Michael Crowley**

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

14. Maiden name **Katherine Brennan**

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

16. (a) Informant **Miss Norinne Herbold**

(b) Address **St. Joseph, Mo.**

17. (a) **Burial** (b) Date thereof **9/23/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Heaton Bowman**

(b) Address **St. Joseph Mo**

19. (a) **9-24-48** (b) **B. G. Jenkins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Buchanan**
 (c) City or town **Rural**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1 Mi. No. on Blackwell Road**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **20**
 year **1948** hour **10** minute **50** P.M.

21. I hereby certify that I attended the deceased from **Sept 20 1948** to **Sept 20 1948**
 that I last saw him alive on **9-20 1948**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thromb. - arteria scl. glo.**
 Duration **1 1/2 hr.**

Due to _____

Due to _____

Other conditions **gfw**
(Include pregnancy within 3 months of death)

Major findings: 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 **Francis M. Deegan** (M. D. or one)
670 Floral Address Date signed **9/21/48**

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

MOTHER FATHER

MAR 91 1949

001 5 70

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.....

Licensed Embalmer No. *3804*

P. O. Address: *319 S. 10th, 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.