

FILED OCT 4 1948

Registration District No. 422

Primary Registration District No. 1000

State File No. \_\_\_\_\_

Registrar's No. 1013

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(c) Name of hospital or institution: State Hospital #2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 yrs. 2 Months  
(Specify whether  
In this community In Institution  
years, months or days)

3. (a) PRINT FULL NAME Gertrude Massey  
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive None given years  
7. Birth date of deceased None given  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>UNKNOWN</u> Probably	<u>30</u>	<u>-?</u>	<u>-?</u>	<u>-</u> hr. <u>-</u> min.

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

10. Usual occupation None

11. Industry or business None

MOTHER FATHER  
12. Name THOMAS MASSEY  
13. Birthplace Harrisburg (City, town, or county) Illinois (State or foreign country)  
14. Maiden name UNKNOWN  
15. Birthplace 9 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs W.M. WEAVER  
(b) Address 1116 1/2 Troost Kansas City Mo.  
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/24/48 (Month) (Day) (Year)  
(c) Place: burial or cremation Kirksville, Mo.

18. (a) Signature of funeral director Heaton Burman  
(b) Address St. Joseph, Mo.  
19. (a) 9-27-48 (Date received local registrar) (b) G. B. Jenkins (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1116 1/2 Troost (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month September day 21  
year 1948 hour 5:30 minute A M.  
21. I hereby certify that I attended the deceased from August 30, 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	Duration
<u>Chronic Myocarditis</u>	<u>2 mo.</u>
Due to <u>Congenital Syphilis</u>	<u>30 yrs.</u>
<u>Paresis</u>	<u>20 yrs.</u>
Due to <u>Syphilis</u>	

Other conditions (Include pregnancy within 3 months of death) 30 J  
Paralysis (Alt Hemiplegia)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(b) Date of occurrence none  
(c) Where did injury occur? none (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no  
While at work? no (Specify type of place) (e) Means of injury none  
23. Signature Forrest Thomas (M. D. or other)  
Address St Joseph Mo Date signed 9/21/48

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

**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 Eugene Wood  
Licensed Embalmer No. 3804  
P. O. Address 319 So 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.**