S. No. 300
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JAN 3 1949

Registration District No. _____

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39431

Primary Registration District No. 1000

Registrar's No. 1381

30 pm

1. PLACE OF DEATH:

(a) County: BUCANON

(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 HOSPT (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 11 hours (Specify whether years, months or days)

In this community: 11 hours

2. USUAL RESIDENCE OF DECEASED: 25

(a) State: MISSOURI (b) County: CLINTON

(c) City or town: CAMERON (If outside city or town limits, write "RURAL") 1

(d) Street No.: CAMERON (If rural, give location) 1

(e) Citizen of foreign country? NO (Yes or No) 1

If yes, name country: _____

3. (a) PRINT FULL NAME: MARTHA JANE ROBERTS

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: Female 1

5. Color or race: White

6. (a) Single, widowed, married, divorced: widow 2

6. (b) Name of husband or wife: NOT STATED

6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: JAN (Month) 18 (Day) 1873 (Year)

8. AGE: Years 73 Months 11 Days 5 If less than one day: hr. _____ min. _____

9. Birthplace: DOWNING (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation: House Keeper

11. Industry or business: Home

MOTHER FATHER

12. Name: THOMAS J. STONEKING

13. Birthplace: STYLER Co MISSOURI (City, town, or county) (State or foreign country)

14. Maiden name: SARAH R. LEWIS

15. Birthplace: CRESTON IOWA (City, town, or county) (State or foreign country)

16. (a) Informant: SAM COURTNEY

(b) Address: ST. Joseph MO.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 12-23-48 (Month) (Day) (Year)

(c) Place: burial or cremation: CAMERON. MO.

18. (a) Signature of funeral director: DeMOSS CRUNK

(b) Address: CAMERON MO.

19. (a) 12-27-48 (Date received local registrar) (b) H. C. Jenkins (Registrar's signature) 24

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23 year 1948 hour 3:20 minute A M.

21. I hereby certify that I attended the deceased from 22 Dec 1948 to Dec 23 1948; that I last saw her alive on 22 Dec 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Generalized peritonitis	7 days
Due to: Perforated acute appendicitis	9 days
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations: none 21

Of autopsy: none

PHYSICIAN: Underline the cause to 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: John R. McDaniel (M. D. or other) M.D.

Address: 902 Edmond St Date signed: 23 Dec 48

(Licensed Embalmer's Statement on Reverse Side) St Joseph, Mo.

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 Lee Moss Crenk

Licensed Embalmer No. 2533

P. O. Address Cameron 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.