

**FEDERAL BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1. PLACE OF DEATH Buchanan Registration District No. 85
 County Buchanan Registration District No. 85
 Townships St. Joseph Primary Registration District No. 1001
 City St. Joseph (No. 4) State Mo (No. 2)
 2. FULL NAME Mary Elizabeth Rathbone
 (a) Residence. No. State Hosp St. Mo Ward.
 (Usual place of abode)
 Length of residence in city or town where death occurred 8 yrs. 2 mos. 17 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

File No. 3757
 Registered No. 1007
 St. Ward

MAR 21 1932

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Unknown</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 30-1930</u>		
7. AGE	YEARS <u>81</u>	MONTHS <u>7</u>
	DAYS <u>2</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) <u>Birmingham</u> (STATE OR COUNTRY) <u>Alabama</u>		
PARENTS	10. NAME OF FATHER <u>Sam Stobley</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY) <u>England</u>	
	12. MAIDEN NAME OF MOTHER <u>Camberson</u>	
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY) <u>Unknown</u>		
14. INFORMANT <u>Records State Hospital #2</u> (Address) <u>St. Joseph, Mo.</u>		
15. FILED <u>2-3, 1932</u> <u>John R. Bender</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan Feb 2- 1932

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1931, to Feb 2, 1932 that I last saw him alive on Feb 1, 1932, and that death occurred, on the date stated above, at 4:35 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
Over (duration) 8 yrs. 2 mos. 10 ds.

CONTRIBUTORY (SECONDARY) Dementia praecox and Hypertension (duration) 8 yrs. 2 mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? no DATE OF
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Dr. Clifton Smith M. D.
Feb 2, 1932 (Address) State Hosp #2
St. Joseph Mo

*State the DISEASE CAUSING DEATH, or Deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Kansas City Mo</u>	DATE OF BURIAL <u>2/2 1932</u>
20. UNDERTAKER <u>W. W. Mayberry</u>	ADDRESS <u>St. Joseph Mo</u>

MARGIN RESERVED FOR BINDING WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

