

REC'D MAY 11 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

14299  
Do not use this space.

1. PLACE OF DEATH 2  
 (a) County Buchanan Registration District No. 85  
 (b) Township Washington Primary Registration District No. 1001  
 or St. Joseph (c) Street No. 6604 Grant Registered No. 422  
 (d) (If death occurred in Hospital or Institution, write its name instead of street and number) St.  
 (e) Length of residence in city or town where death occurred 40 yrs. - mos. - ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mary Mier  
 (a) Residence, No. 6604 Grant St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lewis Ruffing

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 22, 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
65 7 27

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
New York

FATHER 13. NAME John Mier  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
Unknown

MOTHER 15. MAIDEN NAME Unknown  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
Unknown

17. INFORMANT (ADDRESS) Mrs. A.F. Ames  
430 N. 28th Str. Lincoln, Neb.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Olivet Cemt.  
St. Joseph, Mo. DATE April 21 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H.O. Sidenfaden & Son  
1802 Union Str. St. Joseph, Mo.

20. FILED April 20, 1939 H.J. Nestlebrink  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 19 1939.

22. I HEREBY CERTIFY, That I attended deceased from Apr. 18 1939 to Apr. 19 1939  
 I last saw her alive on Apr. 18 1939. Death is said to have occurred on the date stated above, at 1:50 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Cerebral Hemorrhage  
of 21st  
 Date of onset 4/18/39

Other contributory causes of importance:  
Other medical - left 4-15-39

Name of operation none Date of no  
 What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Date of injury, 19      
 Where did injury occur? (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury  
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify (Signed) C. S. Brant M. D.  
 (Address) St. Joseph, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

**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.....

Robert P. Clarkson

Registered Apprentice No. \*\*\*\*\*

working under my personal supervision.

Signed.....

*Robert P. Clarkson*

Licensed Embalmer No. 4028

P. O. Address 1802 Union Str. St. Jose

**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, above space should be left blank.**