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.

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LEG'D JUL 11 1939

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

21578
Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan 3 Registration District No. 85
(b) Township or City St. Joseph / Primary Registration District No. 1001 Registered No. P 615
(c) (d) Street No. 1107 Ridenbaugh St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 360 Lizzie Johanna Yoder
(a) Residence, No. 2222 Dewey Ave., St. Joseph St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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: John Yoder

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): March 5, 1876

7. AGE: YEARS 63 | MONTHS 3 | DAYS 11 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Housewife
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): Peoria, Illinois.

FATHER
13. NAME: John Smith,
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown, Illinois.

MOTHER
15. MAIDEN NAME: Mary Hill,
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown, Illinois.

17. INFORMANT (ADDRESS): Mrs. Marie Ozenberger, Cosby, Missouri RR#1

18. BURIAL, CREMATION, OR REMOVAL PLACE: Memorial Park DATE: June 19, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Walter Meierhoffer, 1302 Faraon, St. Joseph,

20. FILED: June 19, 1939 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): June 16, 1939

22. I HEREBY CERTIFY, That I attended deceased from ? —, 1937 to June 16, 1939
I last saw her alive on June 16, 1939 Death is said to have occurred on the date stated above, at 3:25 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Nephritis (Chronic) Porenchymatous	1937
131	
Other contributory causes of importance: Dementia Senile	1937

Name of operation — Date of
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) [signature], M. D.
(Address) Central Bldg., St. Joseph

(Licensed Embalmer's Statement on Reverse Side)

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 John C. Anderson

Licensed Embalmer No. Mo. 4056

P. O. Address St. Joseph, Missouri

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.