FILED MAR 11 1940

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

5943
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan — Registration District No. 85

(b) Township 3 — Primary Registration District No. 1001 — Registered No. 144

(c) or City St. Joseph — (d) Street No. State Hospital #2 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 6 yrs. 2 mos. 23 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 436 Viola Walters 0 (2233 Lawn St.)

(a) Residence, No. [illegible] St. Kansas City Mo.
(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*): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: not known

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): ?? 1892

7. AGE: about 48 YEARS — MONTHS: Unknown — DAYS: Unknown — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Housework
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): Kansas Unknown 9

FATHER
13. NAME: Antonia Cederbrand
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): ~~Kansas~~ Unknown Kansas

MOTHER
15. MAIDEN NAME: Alma Segoic
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): ~~Kansas~~ Unknown Kansas

17. INFORMANT (ADDRESS): Hospital records St. Joseph Mo.

18. BURIAL, CREMATION, OR REMOVAL — PLACE: State Hospital #2 — DATE: Feby 10 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS): E. R. Sidenfader F. Home 602 So. 10th Street

20. FILED: 2/12 1940 N. J. Nestlebush, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): February 7, 1940

22. I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1937 to Feb. 7, 1940
I last saw her alive on February 7, 1940. Death is said to have occurred on the date stated above, at 6:00 m. A. M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Broncho-pneumonia	1/20/40
107	

Other contributory causes of importance:

Dementia Praecox	12/5/33
Undernourishment	2 Mos.

Name of operation: Date of:
What test confirmed diagnosis? Clinical Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no 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) O. H. Barnethire, M. D.
85 (Address) State Hospital No 2

(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.

50M-9-19-38 X16605

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 Mot. Embalmed. ....., Registered Apprentice No. ....., working under my personal supervision.

Signed R V Werst.

Licensed Embalmer No. 3876

P. O. Address 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, above space should be left blank.