

MAY 13 1940

State File No. \_\_\_\_\_

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 434

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Joseph's Hospital /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 weeks  
In this community 43 years 10 Mo. 2 days (Specify whether years, months or days)  
360

8. (a) PRINT FULL NAME MINNIE TODD

8. (b) If veteran, name war no 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Roscoe Fulton Todd 6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased June 17th 1896  
(Month) (Day) (Year)

8. AGE: Years 43 Months 10 Days 2 If less than one day: hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St. Joseph Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business home

12. Name James Walter Stepheson

13. Birthplace Buchanan County Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Georgia Liburn

15. Birthplace Quincy Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Vc. Friend  
(b) Address St. Joseph, Mo.

17. (a) Burial (b) Date thereof April 22, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director FLEEMAN & SON, INC.

(b) Address St. Joseph, Mo.

19. (a) Mo. 221940 (b) H. J. Reitelbach  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan  
(c) City or town RURAL  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.R. # 6  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19th year 1940 hour 8 minute 10 A. M.

21. I hereby certify that I attended the deceased from Dec. 19 1938 to April 19 1940 that I last saw her alive on April 18 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomatous - stomach and intestines 18 mo.  
Associated with - Carcinoma of ovaries - Krukenberg type 18 mo.  
Due to \_\_\_\_\_

Other conditions emaciation  
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of ovaries Dec 1938  
Of operation Intestinal obstruction 3/29/40  
Of autopsy none  
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? 85  
(Specify type of place) While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. Gray, M.D. (M.D. or other) \_\_\_\_\_  
Address St. Joseph, Mo. Date signed 4/22/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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**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 C. E. Swan

Licensed Embalmer No. 4082

P. O. Address St Joseph

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 14363

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 454

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buttanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME

Minnie Todd

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 43 Months 10 Days 2 If less than one day hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) June 10, 1940 (b) H. J. Neettlebush  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr day 19 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of stomach and intestines associated with Carcinoma of Ovaries - Pinner's type Primary seat probably in the ovaries - (Pathologist doubts if it was true Krukenberg type)  
Due to Carcinoma of Ovaries - Pinner's type Primary seat probably in the ovaries - (Pathologist doubts if it was true Krukenberg type)  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of ovaries  
Intestinal obstruction  
Of autopsy no autopsy

PHYSICIAN'S SIGNATURE \_\_\_\_\_  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature C. S. Grant (M. D. or other) \_\_\_\_\_  
Address St. Joseph Mo. Date signed \_\_\_\_\_

SUPPLEMENTAL

S-14363