DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 10 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17870

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 511

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

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: 2022 Dewey Avenue (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ✓ (Specify whether) 2

In this community 66 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph (If outside city or town limits write "RURAL")

(d) Street No. 2022 Dewey Avenue (If rural, give location) 0

(e) If foreign born, how long in U. S. A.? ✓ years.

3. (a) PRINT FULL NAME Mary Josephine Stumpf 351

3. (b) If veteran, name war ✓

3. (c) Social Security No. none

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Casper

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased July (Month) 24 (Day) 1873 (Year)

8. AGE: Years 66 | Months 9 | Days 10 | If less than one day ___ hr. ___ min.

9. Birthplace St. Joseph (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Housewife

11. Industry or business Own Home 6

FATHER
12. Name Unknown Edelbrock 1
13. Birthplace Unknown (City, town, or county) Germany (State or foreign country) 6

MOTHER
14. Maiden name Gertrude Unknown
15. Birthplace Unknown (City, town, or county) Germany (State or foreign country)

16. (a) Informant Mrs. Henry Voss

(b) Address 2605 Edmond, St. Joseph, Missouri

17. (a) burial (Burial, cremation, or removal) (b) Date thereof May 7, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet St. Joseph, Missouri

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 1302 Faraon, St. Joseph, Missouri

19. (a) May 6 1940 (Date received local registrar) (b) H. Frettlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4th year 1940 hour 8:45 minute P M.

21. I hereby certify that I attended the deceased from Apr 27, 1940, to May 4, 1940, that I last saw her alive on May 4, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypertension	3 Mo
Cardiac Hypertrophy	
~~Due to~~ Glomerular Nephritis	
Marked Oedema of	
~~Due to~~ legs	
Myocarditis	

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

Major findings: Of operations ✓

Of autopsy no

PHYSICIAN — 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? (Specify type of place)

85 While at work? (e) Means of injury

23. Signature Owen W. Craig (M. D. ~~or other~~) 1

Address St. Joseph Mo Date signed 5-6-40

(Licensed Embalmer's Statement on Reverse Side)

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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 W. H. Kelly

Licensed Embalmer No.....

P. O. Address.....

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

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

E. No. 2B
—2-21-40
I X22659

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

OWENA MOORE

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STANDARD CERTIFICATE OF DEATH

State File No. 17870

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 511

SUPPLEMENTARY

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:
(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)

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.

3. (a) PRINT FULL NAME Mary Josephine Stumpf

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid

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 66 Months 9 Days 10 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

19. (a) July 18, 1940 (Date received local registrar) (b) H. J. Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4 year 1940 hour minute M.

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

Immediate cause of death Hypertension — Duration
Cardiac Hypertrophy
Glomerular Nephritis
Due to Edema of lips
Due to Myo Carditis
Other conditions
(Include pregnancy within 3 months of death)
Major findings: Chronic
Of operations
Of autopsy

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

23. Signature Owen D. Craig (M. D. or other)
Address St. Joseph Mo. Date signed

S-17870