

V. S. No. 2
M-11-10
Rev. 5-17-35
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27948**
Registrar's No. **842**

Registration District No. **85**

Primary Registration District No. **1001**

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

1. PLACE OF DEATH:
(a) County **Buchanan**
(b) City or town **St. Joseph**
(c) Name of hospital or institution: **2415 South 4th St**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **35 years**
In this community **35 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Ella Habernal**
3. (b) If veteran, name war **none**
3. (c) Social Security No. **none**

4. Sex **Female**
5. Color or race **white**
6. (a) Single, widowed, married, divorced **widow**

6. (b) Name of husband or wife **Peter**
6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **August 24th, 1870**
(Month) (Day) (Year)

8. AGE: Years **69** Months **11** Days **7**
If less than one day hr. min.

9. Birthplace **Mt. Moriah, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**
11. Industry or business **Home**

MOTHER, FATHER { 12. Name **Francis Broughton**
18. Birthplace **unknown**
14. Maiden name **unknown Harrison**
15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Beatrice Loeffring**
(b) Address **317 Indiana**
Aug 3, 1940

17. (a) **Burial** (b) Date thereof **Aug 3, 1940**
(Burial, cremation or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. Olivet Cemetery**

18. (a) Signature of funeral director **Tracy Barry Funeral**
(b) Address **218 South 10th St**
Home

19. (a) **Aug 3, 1940** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

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. **2415 South 4th St**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? **years**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **1st**
year **1940** hour **2** minute **05 P** M.

21. I hereby certify that I attended the deceased from **June 10, 1940** to **Aug 1, 1940**
that I last saw him alive on **Aug 1, 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chylous ascites of stomach**
Prunony

Due to **46**
Due to **Anemia ferid.**
Other conditions (Include pregnancy within 3 months of death) **July 40**

Major findings: **none**
Of operations **no**
Of autopsy **no**

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? _____

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While at work? (Specify type of place) _____
(e) Means of injury _____
23. Signature **[Signature]** (M. D. or other) _____
Address **Lawrence 317** Date signed **3/2/40**

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 E. Myers

Licensed Embalmer No.

3220

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.