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7-39
K23159

Registration District No. 85

Primary Registration District No. 5127

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Washington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
R.F.D.#6. Kirschners Addition
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None
(Specify whether years, months or days) 2

In this community 40 years.

3. (a) PRINT FULL NAME Pitronela Thomas

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 Widowed

6. (b) Name of husband or wife Stephen Thomas

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

7. Birth date of deceased About 1881
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>?</u>	<u>?</u>	hr. min.

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

10. Usual occupation At home 7

11. Industry or business 7

12. Name ????? Toszkowna

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

14. Maiden name Unknown

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

16. (a) Informant Frank Thomas

(b) Address R.F.D.#6. St. Joseph, Mo.

17. (a) Burial (b) Date thereof Nov 8, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. OLIVET CEMETERY

18. (a) Signature of funeral director H.O. Sidenfaden & Son

(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) Nov 7, 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 Rural Kirschners Addition
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D.#6. St. Joseph, Mo.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 40 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 5,
year 1940 hour 7: minute 15P M.

21. I hereby certify that I attended the deceased from Aug 1939 to Nov 5, 1940
that I last saw him 63 alive on Nov 1 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cholelithiasis about one year

Due to Cholelithiasis

Due to Cholelithiasis

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

Major findings:
Of operations -

Of autopsy -

Duration

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? 85

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

23. Signature [Signature] (M. D. or other) MD

Address 500 1/2 W. 11th St. Date signed 11/7/40

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 Albert E. Harrington
Licensed Embalmer No. 3258
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, fact should be so stated above.