No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41841

FEB JAN 10 1941

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 1283

1. PLACE OF DEATH:

(a) County: BUCHANAN

(b) City or town: ST. JOSEPH 3

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

(c) Name of hospital or institution: STATE HOSPITAL No. 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 years 8 mo. (Specify whether years, months or days)

In this community 2 yrs 8 months, 20 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Little Blue

(If outside city or town limits, write "RURAL")

(d) Street No.: County Home

(If rural, give location)

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

3. (a) PRINT FULL NAME: HATTIE PEERMAN

3. (b) If veteran, name war: —

3. (c) Social Security No.: None

4. Sex: fem.

5. Color or race: wh.

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

6. (b) Name of husband or wife: Emmett

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

7. Birth date of deceased: June (Month) 29 (Day) 1869 (Year)

8. AGE: Years: 70 Months: 5 Days: 7 If less than one day: ..... hr. ..... min.

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

10. Usual occupation: House work

11. Industry or business: —

FATHER

12. Name: Walter Holman

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

MOTHER

14. Maiden name: Kauwater

15. Birthplace: Clay Cty Mo (City, town, or county) (State or foreign country)

16. (a) Informant: Jewell Ross

(b) Address: 915 Lathrop Detroit Mich

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 9 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Ashland

18. (a) Signature of funeral director: Mrs. E. L. Sidenfaden

(b) Address: 602 South 10th Street 85

19. (a) Dec. 9, 1940 (Date received by local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day 6 Year 1940 hour 11:00 minute P. M.

21. I hereby certify that I attended the deceased from July 1940, 19..., to December 6 1940, that I last saw her alive on December 6 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	2 Days
Due to: Senility	
Due to:	
Other conditions (Include pregnancy within 3 months of death): TB pulmon.	

Major findings: Of operations: —

Of autopsy: Bronchopneumonia, TB pulmon.

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): None

(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: [illegible] (M. D. or other) DMO

Address: State Hospital No. 2 Date signed: 12-7-40

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

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

Mollie E. Sidenfaden, Registered Apprentice No. 145

working under my personal supervision.

Signed R. V. Wersch

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.