

No. 2  
4-13-40  
5-2-39  
I 2249

JUL 10 1941 85  
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  
(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 3 mo, 8 days  
(Specify whether years, months or days)

In this community: " " " "

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison

(c) City or town Rock Port  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location) 0

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

3. (a) PRINT FULL NAME Susan Belle Thomas

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28  
year 1941 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from March 20, 1941, to June 28, 1941;  
that I last saw her alive on June 28, 1941;  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W hite

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

6. (b) Name of husband or wife Robert W. Thomas

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

7. Birth date of deceased: June (Month) 15 (Day) 1862 (Year)

Immediate cause of death Bronchopneumonia

Due to (Organism Undetermined)

Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day

79 0 13 hr. \_\_\_\_\_ min.

Other conditions Decubitus ulcers 14 2/17/41  
(Include pregnancy within 3 months of death)  
Fracture left Femur

Major findings:  
Of operations no operation

Of autopsy no autopsy

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

10. Usual occupation Housewife

MOTHER FATHER

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

12. Name William Atchison

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

14. Maiden name Saphira Hewitt

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence February 17, 1941

(c) Where did injury occur? Rock Port Atchison Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
85 Home

While at work? no (Specify type of place)

(e) Means of injury Fall

23. Signature D.P. Johnson (M. D. or other) M.D.  
Address State Hosp # 2 Date signed 6-28-41

16. (a) Informant Records State Hosp. # 2

(b) Address St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 6--30--41  
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

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

(b) Address St. Joseph, Mo.

19. (a) 6/29/41 (Date received by registrar)

(b) A.J. Westlund (Registrar's signature)

St. Joseph, Mo.

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**