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

X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 13 1942

Registration District No. 85

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1001

State File No. 23917

Registrar's No. 715 ~~638~~

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: Mercy Hospital O (If not in hospital or institution, write street number or location)

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

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County DeKalb 32

(c) City or town Rural - Sherman 0 (If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Myrna Lee Tiffany (Twin)

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 1

5. Color or race W

6. (a) Single, ~~widowed~~, ~~married~~, ~~divorced~~ 0

6. (b) Name of husband or wife

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

7. Birth date of deceased June (Month) 30 (Day) 1942 (Year)

8. AGE: Years | Months | Days 2 | If less than one day br. min.

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

10. Usual occupation none

11. Industry or business —

FATHER
12. Name Maxon Tiffany
13. Birthplace Springfield (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Mary Elizabeth Reynolds
15. Birthplace Vermont (City, town, or county) Ill. 1 (State or foreign country)

16. (a) Informant Max Tiffany

(b) Address Stewartsville Mo.

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

(c) Place: burial or cremation Stewartsville Mo.

18. (a) Signature of funeral director F. G. Lyon

(b) Address Stewartsville Mo.

19. (a) July 2-42 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2 year 1942 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from June 30, 1942 to July 2, 1942 that I last saw her alive on July 2, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Premature birth	7 months
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

159

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 J M Austin (~~M. D. or other~~) D.O.

Address Stewartsville Mo Date signed 7-2-42

12-33 H J Hestermann (Licensed Embalmer's Statement on Reverse Side)

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 w the above constitutes grounds for revocation of license.)

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

6. No. 2B
1—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23917

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 715

WRITE ONLY—USE 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: Mercy
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 days. (Specify whether years, months or days)
In this community:

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) Citizen of foreign country? (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Myrna Lee Tiffany
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:
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: June (Month) 30 (Day) 1942 (Year)
8. AGE: Years | Months | Days | If less than one day: hr. min.
9. Birthplace: (City, town, or county) Mo (State or foreign country)
10. Usual occupation:
11. Industry or business:
12. FATHER Name:
13. FATHER Birthplace: (City, town, or county) (State or foreign country)
14. MOTHER Maiden name:
15. MOTHER Birthplace: (City, town, or county) (State or foreign country)
16. (a) Informant:
(b) Address:
17. (a) (Burial, cremation, or removal) (b) Date thereof: July 2, 1942 (Month) (Day) (Year)
(c) Place: burial or cremation:
18. (a) Signature of funeral director:
(b) Address:
19. (a) July 2, 1942 (Date received by local registrar) (b) Rose Heyong (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: July Day: year: 1942 hour: minute: M.
21. I hereby certify that I attended the deceased from: 19 to: 19;
that I last saw him alive on: 19;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
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)
(b) 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: (M. D. or other)
Address: Date signed:

SUPPLEMENTARY