No. 2
-1-4-41
5-17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 13 1943

Registration District No. 42

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. ~~1001~~ 1000

State File No. 13697

Registrar's No. 460

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 #2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 11 years 1 mo 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City (If outside city or town limits, write "RURAL")
(d) Street No.: 2730 Charlotte (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Lissie Darrow
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: unknown (Month) (Day) 1852 (Year)

8. AGE: Years	Months	Days	If less than one day
91	—	—	____ hr. ____ min.

9. Birthplace: Unknown (City, town, or county) Michigan (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business ____
12. Name (Father): Andrew Jackson
13. Birthplace (Father): Unknown (City, town, or county) U.S.A. (State or foreign country)
14. Maiden name (Mother): Katherine Jackson
15. Birthplace (Mother): Unknown (City, town, or county) U.S.A. (State or foreign country)
16. (a) Informant: Records, State Hosp. #2
(b) Address: St Joseph, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-43 (Month) (Day) (Year)
(c) Place: burial or cremation: State Hospt #2
18. (a) Signature of funeral director: Clark Mortuary
(b) Address: St Joseph, Mo.
19. (a) 4-28-43 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26 year 1943 hour 1:30 minute P. M.
21. I hereby certify that I attended the deceased from November 28, 1942, to April 25, 1943, that I last saw her alive on April 25, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Chr. Myo-carditis	
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)
(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: R B Swearingen (M.D. ~~or other~~)
Address: State Hosp. #2 Date signed 4-26-43

1233 (Licensed Embalmer's Statement on Reverse Side) 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 not embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....Emma Clark

Licensed Embalmer No.....4235

P. O. Address.....St Joseph.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

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