

ED AUG 5 1943

State File No.

730

Registration District No. 42

Primary Registration District No. 1000

Registrar's No.

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:
2417 So 19th /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community **19 Years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **2417 So. 19th**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mollie Pettis**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Nelson Pettis** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **February 20 1875**
(Month) (Day) (Year)

8. AGE: Years **68** Months **4** Days **8** If less than one day _____ hr. _____ min.

9. Birthplace **Texas /**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Hanse Finney**

13. Birthplace **Texas /**
(City, town, or county) (State or foreign country)

14. Maiden name **Lottie Watson**

15. Birthplace **Tenn. /**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Jackie De Lance**

(b) Address **2417 So 19th, St Joseph, Mo**

17. (a) **Burial** (b) Date thereof **6-29-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cem.**

18. (a) Signature of funeral director **Fleeman & Son Inc.**

(b) Address **1946 Colhoun St.**

19. (a) **6-29-43** (b) **Rose Hergoy**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **28th**
year **1943** hour **2** minute **20** A.M.

21. I hereby certify that I attended the deceased from **6-15-43** to **6-28-43**
that I last saw her alive on **6-25-43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic nephritis** Duration **2 mo.**

Due to **Sulfa drug - kidney block** 2 mo.

Due to **Lobar pneumonia**

Other conditions **Obesity**
(Include pregnancy within 2 months of death)

Major findings: **Decubitus ulcers**

Of operations **none**

Of autopsy **none**

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?

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

23. Signature **W. Grant** (M. D. or other) **MD**

Address **St Joseph, Mo** Date signed **6-28-43**

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

MOTHER FATHER

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 _____

_____ Apprentice No. _____

working under my personal supervision.

Signed Robert H. Apple

Licensed Embalmer No. 3308

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.