

No. 2
1-4-41
5-17

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27688

State File No. _____

FILED SEP 8 1943 42

Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 931

1. PLACE OF DEATH: BUCHANAN
 (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: St. Joseph's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 25 Years (Specify whether years, months or days)
 In this community _____

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. 404 1/2 St. Joseph's Hospital
 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME KATE CALDWELL
 3. (b) If veteran, name war NO
 3. (c) Social Security No. _____

4. Sex Female 5. Color or Race NEGRO 6. (a) Single, widowed, married, divorced, WIDOWED
 6. (b) Name of husband or wife Deceased (c) Age of husband or wife if alive _____ years (Day) (Year)
 7. Birth date of deceased: Aug 1 1888 (Month) (Day) (Year)

8. AGE: Years 55 Months 00 Days 00 If less than one day _____ hr. _____ min.

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

10. Usual occupation Domestic

11. Industry or business " " "

MOTHER FATHER { 12. Name David Midgett
 13. Birthplace Unknown (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Lena Ware
 (b) Address 1617 Waldron Ave

17. (a) K. C. Mo. (b) Date thereof Aug 13, 43 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation K# C. Mo.

18. (a) Signature of funeral director RANSEY & SON'S MORT
 (b) Address 1602 Messanie St

19. (a) 8/12/43 (b) Rae Helyoy (Date furnished local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 8th year 1943 hour 12 minute 45 P.M.

21. I hereby certify that I attended the deceased from August 6, 1943 August 8, 1943 that I last saw her alive on August 8, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Acute intestinal obstruction 6 days

Due to Intersusception Fibro myoma of uterus (2)

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 122 f 2
 Of autopsy _____

Duration

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 Clayton Smith (M. D. or other) M.D.
 Address - Socie Welfare Board Date 8/11/43

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

1233

(Licensed Embalmer's Statement on Reverse Side) St Joseph Mo

SEP 8 1943

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..... *J. A. Ramsey*

Licensed Embalmer No. *8041*

P. O. Address *160 1/2 Jackson*

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.