

**FILED DEC 1 1943**  
Registration District No. 1000

Primary Registration District No. 1000

Registrar's No. 1239

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:  
620 Hamburg Ave.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community 33 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 011

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 620 Hamburg  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME IRA SESSIONS

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Elmira Z. Sessions

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

7. Birth date of deceased Jan. 2 1868  
(Month) (Day) (Year)

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

75	10	3	hr. _____ min.
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9. Birthplace Caldwell county Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Railroad Millright

11. Industry or business retired

MOTHER FATHER { 12. Name Ira Sessions

13. Birthplace New York 1  
(City, town, or county) (State or foreign country)

14. Maiden name Polly

15. Birthplace New York 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. T. A. Jackson

(b) Address 620 Hamburg

17. (a) burial (b) Date thereof 11/12/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn

18. (a) Signature of funeral director Berde & Bowman

(b) Address 319 South 10th

19. (a) 11/10/43 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 10  
year 1943 hour 4 minute 10 A. M.

21. I hereby certify that I attended the deceased from Nov. 8 1943 to Nov. 10 1943  
that I last saw him alive on Nov. 8, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy Duration 4 days

Due to Arterio-sclerosis & arterial hypertension may

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

Other conditions 93a1  
(Include pregnancy within 3 months of death)

Major findings: Of operations none PHYSICIAN \_\_\_\_\_

Of autopsy none

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 S. T. Blomert M.D. M. D. or other M.D.

Address 1218 N. 38 St. Joseph, Mo. Date signed 11/10/43

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

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 *Elmer Thomas*

Licensed Embalmer No. *2640*

P. O. Address *St Joseph*

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

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

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. See  
Registrar's No. 1289

Registration District No. 42 Primary Registration District No. 1000

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

3. (a) PRINT FULL NAME Joe Sessions  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w  
6. (a) Single, widowed, married, divorced w  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if  
alive..... years  
7. Birth date of deceased Jan 2 1900  
(Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days..... If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

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

16. (a) Informant.....  
(b) Address.....

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

18. (a) Signature of funeral director.....  
(b) Address.....

19. (a) (Date received local registrar) (b) Rose Herzog (Registrar's sign. (date))

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.....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 10  
year 1943 hour..... minute..... M.  
21. I hereby certify that I attended the deceased from..... 19.....  
that I last saw him..... alive on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

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?  
While at work?..... (Specify type of place) (e) Means of injury.....  
23. Signature..... (M. D. or other)  
Address..... Date signed.....

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