

No. 2  
5-43  
5-17-39  
X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2091

State File No. \_\_\_\_\_

FILED FEB 9 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 1000

Registrar's No. 89

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:  
Mo. Methodist Hosp  
(If not in hospital or institution, write street number or location)

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

In this community 32 yrs  
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. 837 So 18th  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Jessie G. Carpenter

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 Married

6. (b) Name of husband or wife James B. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 12 1888  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22  
year 1944 hour 7 minute 45 P. M.

21. I hereby certify that I attended the deceased from Jan 21, 1944, to Jan 22, 1944  
that I last saw her alive on Jan 22, 1944  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>55</u>	<u>1</u>	<u>10</u>	hr. _____ min. _____

Immediate cause of death \_\_\_\_\_

Due to meningitis de non contages middle ear infection 2 da.

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

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

10. Usual occupation Seamstress Sub Depot

11. Industry or business U.S. Civil Service

MOTHER FATHER { 12. Name William King

13. Birthplace Ill.  
(City, town, or county) (State or foreign country)

14. Maiden name Nancy J. Jones

15. Birthplace Ill  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Jessie M. Bobb

(b) Address RS. St Joseph

17. (a) Burial (b) Date thereof 1-28-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Auburn

18. (a) Signature of funeral director Flemonson Inc

(b) Address St Joseph, Mo.

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy Inflammation of meninges

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 H. D. Kirby (M. D. or \_\_\_\_\_)

Address St Joseph Mo Date signed 1-24-44

Duration

2 da.

2 da.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

*Robert H. Goble*

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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FEB

State File No. \_\_\_\_\_

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 99

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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Jessie C. Carpenter

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 m

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

7. Birth date of deceased Dec 12  
(Month) (Day) (Year)

8. AGE: Years 55 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Rose Herzog  
(Date received local registrar) (Registrar's signature)

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 22 Year 1944 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the decedent from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her 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 \_\_\_\_\_

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 \_\_\_\_\_

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

SUPPLEMENTAL

MOTHER FATHER

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

MAR 6 1944

2091