No. 2-
-9-4-41
-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 15 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6561

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 225

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph Mo
(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 4 mos 4 days (Specify whether
In this community yes
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Nodaway
(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 2519 Rochester Ave
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Minerva Connaway
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 widowed
6. (b) Name of husband or wife Deceased
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 57 Months Days If less than one day hr. min.

9. Birthplace Knobnoster Mo 0
(City, town, or county) (State or foreign country)
10. Usual occupation House wife
11. Industry or business at home
FATHER
12. Name Not given
13. Birthplace Not given
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name not given
15. Birthplace not given
(City, town, or county) (State or foreign country)
16. (a) Informant Mrs Jannita Spate
(b) Address 2519 Rochester ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/44 (Month) (Day) (Year)
(c) Place: burial or cremation Knobnoster Mo
18. (a) Signature of funeral director R.R. Spencer
(b) Address Indep. Mo
19. (a) 1-27-44 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1/25 day
year 1944 hour 11 45 minute a M.
21. I hereby certify that I attended the deceased from Jan 17, 1944 to Jan 25, 1944
that I last saw her alive on Jan 25, 1944
and that death occurred on the date and hour stated above.
Immediate cause of death Hypostatic pneumonia — Duration 5 days
Due to Post haemoplegic condition of the brain Doubtful
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION
Of autopsy REQUESTED

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 0
23. Signature C. E. Cossing (M. D. or other)
Address State Hospital #2 St Joseph Mo Date signed 1/25/1944

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(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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

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

. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 225

SUPPLEMENTARY

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)

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

3. (a) PRINT FULL NAME Minerva Coundly

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 W

6. (b) Name of husband or wife

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

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

8. AGE: Years 57 Months — Days — If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day 25 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia Lobar — Duration 3 days.

Due to Post holmesplegia condition of the brain — D.K.

Due to

Other conditions (Include pregnancy within 3 months of death)

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Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 [signature] (M. D. or other)

Address Date signed

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