

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 165

FILED FEB 29 1944
Registration District No. 42

Primary Registration District No. 1080

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 State Hosp # 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 27 months
(Specify whether years, months or days)
 In this community same

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
 (c) City or town KE
(If outside city or town limits, write "RURAL")
 (d) Street No. 515 Broad
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mina Rubin
 3. (b) If veteran, name war ✓
 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15
 year 1944 hour 1 minute 50 A. M.
 21. I hereby certify that I attended the deceased from 4-12
 1943 to 2-14 1944
 that I last saw her alive on 2-14 1944
 and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, 2 divorced Widowed
 6. (b) Name of husband or wife ? 6. (c) Age of husband or wife if alive ? years
 7. Birth date of deceased Unknown
(Month) (Day) (Year)

Immediate cause of death Hypostatic broncho pneumonia Duration 4 days

8. AGE: Years Months Days If less than one day
Unknown - probably 70 years

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

Due to Cancer of uterus
 Due to _____
 Other conditions H&R
(Include pregnancy within 3 months of death)

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)

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Hospital records
 (b) Address _____
 17. (a) Removal (b) Date thereof 2-15-44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation R.G. no. 1
 18. (a) Signature of funeral director Louise
 (b) Address R.C. no. 1
 19. (a) 2-15-44 (b) Rose Herzog
(Date received local registrar) (Registrar's signature)

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 E.H. Magee (M. D. or other) M.D.
 Address State Hosp # 2 Date signed 2/15/44

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 with the above constitutes grounds for revocation of license.)

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