

Registration District No. **42** Primary Registration District No. **1000**

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:
1325 So Hayes Blvd
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **72 yrs** (Specify whether 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. **1325 So Hayes Blvd**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Elizabeth Borngesser**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan** day **28** year **1945** hour **11** minute **50A** M.
21. I hereby certify that I attended the deceased from **Sept 24** 19**44** to **Jan 28** 19**45**
that I last saw her alive on **Jan 16** 19**45** and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Oscar** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **April 9 1872**
(Month) (Day) (Year)

Immediate cause of death: **Cardio-Vascular Renal Crisis** Duration **6 months**
Due to **Arterio Sclerosis** **3 yrs.**
Due to _____
Other conditions: **Injury to scleral vessels of R. leg** **4 months**
(Include pregnancy within 5 months of death)

8. AGE: Years **72** Months **9** Days **19** If less than one day _____ hr. _____ min.
9. Birthplace: **St Joseph Mo. U**
(City, town, or county) (State or foreign country)
10. Usual occupation: **Housewife**

Major findings: **no operation** ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of operations _____
Of autopsy: **no autopsy**
Underline the cause to which death should be charged statistically.

MOTHER FATHER {
12. Name **Adam Rice**
13. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)
16. (a) Informant **Herman Borngesser**
(b) Address **St Joseph, Mo**
17. (a) **Burial** (b) Date thereof: **2-1-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Ashland Cem.**
18. (a) Signature of funeral director **Fleeman & Son Inc**
(b) Address **St Joseph, Mo**
19. (a) **2-1-45** (b) **Thelma J. Thelma**
(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) **✓ 131**
(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: **Gordon D. Swift M.D.** (M. D. or other)
Address **845 S. 19th St. St. Joe, Mo** Date signed **1/30/45**

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

1377

FEB 26 1945

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. Yaph*
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

State File No. 1692

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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 72 yrs years, months or days) (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Elizabeth Bernegger
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 wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 1892 (Month) (Day) (Year)

8. AGE: Years 72 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation housewife

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) _____ (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) _____ (b) _____ (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 28 Year 1945 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Aortic Sclerosis Duration 3 yrs

Due to Inherited Hypertension ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 1860/9 4 yrs

Due to _____

Other conditions Injury to sclerosed (Include pregnancy within 9 months of death)

Major findings: fracture of right hip all to floor while attempting to get out of bed in the morning chance of the nurse for the Underline the cause to which death should be charged fracture of hip

22. If death was due to external causes, all in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Nov 20, 1944

(c) Where did injury occur? her home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In her bedroom

While at work? no (Specify type of place) (e) Means of injury fall out of bed

23. Signature Donald J. Smith M.D. (M. D. or other) 645-5019 at St Joseph Date signed Dec 30, 1945

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

MOTHER FATHER

SUPPLEMENTARY

