

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JAN 27 1945**

MISSOURI STATE BOARD OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_  
Registrar's No. 40

Registration District No. 42 Primary Registration District No. 1005

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 Hospital No. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Mo 22 days  
(Specify whether years, months or days) 1

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Mo (b) County Jackson  
(c) City or town Kansas City 11  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2104 College (If rural, give location) 7  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** ALBEYTA COMBS  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. 2

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Jan. day 7  
year 1945 hour 5-15 minute 2 A.M.

4. Sex F 1. Color or race W 2. (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 Nov 29 1903  
(Month) (Day) (Year)

**21. I hereby certify that I attended the deceased from** 12-8, 1944 to 1/7, 1945  
that I last saw her alive on 1-6, 1945  
and that death occurred on the date and hour stated above.

**8. AGE:** Years 41 Months 1 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Hypostatic Pneumonia Bronchial  
Due to Aid ridden general debility  
Due to \_\_\_\_\_  
Other conditions Tabo Paresis  
(Include pregnancy within 3 months of death)

**MOTHER FATHER**  
12. Name Bert M. Elmer  
13. Birthplace Mo 0  
(City, town, or county) (State or foreign country)  
14. Maiden name Mar Duncan  
15. Birthplace Mo 11  
(City, town, or county) (State or foreign country)

**PHYSICIAN**  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant Richard Hospital No. 2  
(b) Address State St Joseph Mo  
17. (a) Removal (b) Date thereof 1-7-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation F. C. Mc  
18. (a) Signature of funeral director W. C. Mc  
(b) Address St. Joseph Mo  
19. (a) 1-7-45 (b) Allen J. Stable  
(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 0  
**23. Signature** W. C. Mc (M. D. or other) \_\_\_\_\_  
Address St Joseph Mo Date signed 1/7/45

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**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.**