

FILED FEB 13 1945

Registration District No. 22

Primary Registration District No. 1000

Registrar's No. 72

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. No. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 43 yrs  
(Specify whether years, months or days) unknown

In this community unknown

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. 1516 Highly Street  
(If rural, give location)

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

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

3. (a) PRINT FULL NAME Emma T. Reese

3. (b) If veteran, name war ✓ 3. (c) Social Security No. none

4. Sex female 5. Color or race wh 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Reuben Reese 6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased unknown 1864  
(Month) (Day) (Year)

8. AGE: Years 80 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace unknown 1 Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation none

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

MOTHER FATHER { 12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Hospital records  
(b) Address St. Joseph

17. (a) Burial (b) Date thereon Jan. 12, 1945  
(Burial, cremation, or removal) (Month) (Year)

(c) Place: burial or cremation State Hospital Cemetery

18. (a) Signature of funeral director M. E. S. DENNEN  
(b) Address 602 So. 12 St.

19. (a) 1-12-45 (b) Nelson H. Fickler  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 11 year 1945 hour 7 minute 40 A.M.

21. I hereby certify that I attended the deceased from 3-1-1944 to Jan. 10, 1945  
that I last saw h. or alive on Jan 10, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Semility  
Arthritis

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

Other conditions Semile psychosis paranoid  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy none

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 Dora Holdorf M.D. (M. D. or other) \_\_\_\_\_  
Address State Hosp. No 2 St. Joseph Date signed 1/12/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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.**