

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 24 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16586**

Registration District No. **59**

Primary Registration District No. **5227**

Registrar's No. **64**

1. PLACE OF DEATH:

(a) County Cass

(b) City or town Rural Peculiar Twp
(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 2 1/2 yr.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass

(c) City or town Harrisonville (Rural)
(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 CATHERINE FRANCES STODDARD

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Genl Stoddard 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 19 1898
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>2</u>	<u>23</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name James Joseph Owens

13. Birthplace Don't know
(City, town, or county) (State or foreign country)

14. Maiden name Galia Mary Jones

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant James Joseph Owens

(b) Address 31227 Brooklyn St C 9 Mo

17. (a) Rural (b) Date thereof May 5 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Orient Cemetery

18. (a) Signature of funeral director RUNNENBURGER'S

(b) Address HARRISONVILLE, MO

19. (a) May 5, 1945 (b) Margaret M. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April, Day 29, Year 1945 hour 1:00 minute AM M.

21. I hereby certify that I attended the deceased from April 29, 1945, to May 3, 1945; that I last saw her alive on May 2, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion

Due to Arterio-sclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations None Of autopsy _____

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

(c) 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) (c) Means of injury _____

23. Signature Dr. C. J. Guerrett (M. D. or other) D.O.
Address Harrisonville, Mo. Date signed May 5, 1945

Duration

1 hr.

5 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

009

r.c.

1047

(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 Ernest Remminger

Licensed Embalmer No. 3368

P. O. Address Harrisonville 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.