

Form No. 2
 DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 5-17-39
 X37823

26818

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 SEP 4 1945

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____
 Registrar's No. 867

Registration District No. 42

Primary Registration District No. 000

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:
In Ambulance on way to St. Joseph Hospital?
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Not
(Specify whether years, months or days)
 In this community 27 years

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. Rural #4, Pickett Road
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Hattie Attrill
 (b) If veteran, name war No
 (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month August day 9th
 year 1945 hour 8 minute 30 a. M.
 21. I hereby certify that I attended the deceased from Aug 9th
45 1945 to _____ 19 ;

4. Sex Female / 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife E. L. Attrill
 (c) Age of husband or wife if alive 63 years
 7. Birth date of deceased August 10 1892
(Month) (Day) (Year)

that I last saw h. _____ alive on _____ 19 ;
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
 Duration _____

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|-----------|-----------|----------------------|
| | <u>52</u> | <u>11</u> | <u>29</u> | hr. _____ min. _____ |

Due to _____
 Due to _____

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

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

10. Usual occupation Housewife

Major findings: Of operations _____
 Of autopsy _____

11. Industry or business _____
 12. Name Thomas Kier
 13. Birthplace Albany Missouri
(City, town, or county) (State or foreign country)
 14. Maiden name Julia Sampson
 15. Birthplace Albany Missouri
(City, town, or county) (State or foreign country)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant E. L. Attrill
 (b) Address R.R. #4, St. Joseph, Missouri
 17. (a) Burial (b) Date thereof 8/10/1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Memorial Park Cemetery

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? _____

18. (a) Signature of funeral director Walter Neierhoffer
 (b) Address 1302 Faraon, St. Joseph, Missouri
 19. (a) 8-10-45 (b) Nelen J. Finkle
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____
 23. Signature B. W. Tadlock Coroner
 Address King Hill Bldg Date signed 8/10/45

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

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.....

Albert R. Harrington

Licensed Embalmer No..... 3258 Missouri

P. O. Address..... St. Joseph, Missouri.

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.