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Rev. 5-17-39
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30182

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 994

Registration District No. 42 Primary Registration District No. 1000

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

1. PLACE OF DEATH:
Buchanan
(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:
AT HOME, 1026 Angeliqne
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Most of Life
years, months or days)

3. (a) PRINT FULL NAME LAURA SPEERS.
(b) If veteran, NO name war _____
(c) Social Security No. NO

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife James E. Speers
6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased June 19th, 1878
(Month) (Day) (Year)

8. AGE: Years 67 Months 2 Days 26
If less than one day _____ hr. _____ min.

9. Birthplace Austin, Texas
(City, town, or county) (State or foreign country)
Housesville.

10. Usual occupation Home

11. Industry or business John Parke

12. Name _____
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Rose Sutton
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant James R. Speers
(b) Address 1026 Angeliqne

17. (a) Burial (b) Date thereof Sept. 18, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Mrs. E. R. Sidenfaden
(b) Address 602 South 10th Street

19. (a) 9-20-45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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. 1026 Angeliqne Street /
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 14th
year 1948 hour About 9 minute A M.
21. I hereby certify that I attended the deceased from viewed
Sept 14th 1948 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 Mitral Insufficiency
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) none

Major findings: 921
Of operations _____
Of autopsy no

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 B.W. Tadlock Coroner 2
(M. D. coroner)
Address King Hill Bldg Date signed 9/14/48

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

1828

(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 *Mollie E. Sidenaden Fox*

Licensed Embalmer No. *4235*

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.