V. S. No. 2
50M—9-4-41
Rev. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

FILED JAN 8 1946

STANDARD CERTIFICATE OF DEATH

State File No. 40524

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1317

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 # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 yrs 9 mos 14 days (Specify whether
In this community 15 yrs. 9 mos. 14 Days. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 11

(c) City or town K. C. 1
(If outside city or town limits, write "RURAL")

(d) Street No. 2937 Wabash 7
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME MARY J BERTRAND

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced Single 1

6. (b) Name of husband or wife 1

6. (c) Age of husband or wife if alive years

7. Birth date of deceased May (Month) 9 (Day) 1884 (Year)

8. AGE: Years 61 Months 7 Days 0 If less than one day hr. min.

9. Birthplace St Marys (City, town, or county) Kas 1 (State or foreign country)

10. Usual occupation Stenographer 1

11. Industry or business 1

FATHER
12. Name Bernard Bertrand
13. Birthplace Niles (City, town, or county) Mich 1 (State or foreign country)

MOTHER
14. Maiden name Catherine Fureau
15. Birthplace Mayville (City, town, or county) Wis 1 (State or foreign country)

16. (a) Informant Mrs. R J Holloway 1
(b) Address K.C. Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-9-1945 (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Walter Meierhoffer
(b) Address St. Joseph Missouri

19. (a) Dec. 10, 1945 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 9
year 1945 hour 7:35 minute A M.

21. I hereby certify that I attended the deceased from Dec 3rd 1945, to Dec 8 1945
that I last saw her alive on Dec 8 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Due to Haemolytic blood stream infection

Due to Haemorrhage of the brain

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Cystitis, haemorrhage into stomach, bladder.
Of autopsy Dec. 9 temporal haemorrhage

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature T. A. Cannichan (M.D. or other M.D.)

Address State Hosp. # 2 ST. JOSEPH Date signed 12/9/45

1428

(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 Albert C. Harrington

Licensed Embalmer No. 3258. Mo

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.