

BUREAU OF THE CENSUS
FILED

8 1946 STANDARD CERTIFICATE OF DEATH

State File No. **4703**

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **215**

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:
3110 Lafayette Street
 (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) **45 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. **3110 Lafayette Street.**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Fatima Charlotte Will**

MEDICAL CERTIFICATION

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

20. DATE OF DEATH: Month **February** day **11th.**
 year **1946** hour **4** minute **45 p. M.**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Albert M. Will** 6. (c) Age of husband or wife if alive **62** years
 7. Birth date of deceased **May 31 1885**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Jan 10** 19**46**, to **Feb. 11** 19**46**;
 that I last saw her alive on **Feb 11** 19**46**;
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
60 **8** **10** hr. min.

Immediate cause of death **Pneumo-pneum.** Duration **7/11/46**
 Due to **Cerebral Hemorrhage.** **1/15/46**

9. Birthplace **Stark County Illinois**
 (City, town, or county) (State or foreign country)

Due to **Anterior tub. gen.**
 Other conditions **Retinal Hemorages.**
 (Include pregnancy within 3 months of death)

10. Usual occupation **Housewife**

Major findings: Of operations _____
 Of autopsy **92!**
 Underline the cause to which death should be charged statistically.

11. Industry or business _____
 12. Name **Thomas Jasper Bocock**
 13. Birthplace **Stark County Illinois**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Nancy Frances Proctor**
 15. Birthplace **Henry County Illinois**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Albert M. Will**
 (b) Address **3110 Lafayette, St. Joseph, Missouri**
 17. (a) **Burial** (b) Date thereof **2/13/1946**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Mt. Auburn Cemetery**
 18. (a) Signature of funeral director **Walter Meierhoffer**
 (b) Address **1302 Faron, St. Joseph, Missouri.**
 19. (a) **Feb. 21, 1946** (b) **[Signature]**
 (Date received local registrar) (Registrar's signature)

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 **[Signature]** (M. D. or other) **0**
 Address **670 Olvera** Date signed **2/10/46**

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

3727

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 P. 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.