

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8547**
Registrar's No. **272**

FILED APR 10 1946
Registration District No. **42**

Primary Registration District No. **1000**

1. PLACE OF DEATH:

(a) County Buchanan County
(b) City or town St. Joseph Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None. 103 - South 16th
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None (Specify whether
In this community 1 year. (years, months or days)

3. (a) PRINT FULL NAME Nancy Ann Draiss

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

4. Sex Female 5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Robert Draiss
6. (c) Age of husband or wife if alive --- years
7. Birth date of deceased Jan 1 1858
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>88</u>	<u>2</u>	<u>2</u>	hr. min.

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

10. Usual occupation House Keeping

MOTHER FATHER

11. Industry or business
12. Name James M. Vestal
13. Birthplace North Carolina
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Williams
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Manuel Hudson
(b) Address Dearborn Missouri

17. (a) R&Burial (b) Date thereof 3/3/1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Davis Chappel

18. (a) Signature of funeral director Russian Davis
(b) Address Dearborn Missouri

19. (a) Mar. 7, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Platte **83**
(c) City or town Dearborn Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. ---
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3
year 1946 hour --- minute 30 M.

21. I hereby certify that I attended the deceased from March 2
1946 to March 3, 1946
that I last saw her alive on March 2, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Duration Sind-Per

Due to Old age & fractured femur
Antemortem

Due to None
Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations None
Of autopsy No
Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? None (e) Means of injury None

23. Signature [Signature] (M. D. or other)
Address Dearborn Mo Date signed 3-3-46

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

Russell Davis

Licensed Embalmer No.

4160

P. O. Address:

Deaton, 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.

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH: Buchanan St Joseph
(a) County
(b) City or town
(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 _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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 Nancy Ann Crain
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased: Jan (Month) 1 (Day) 19 (Year)
8. AGE: Years 88 Months 2 Days _____ (Less than one day) hr. _____ min.

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

MOTHER FATHER

11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ year 1946 M. _____
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____ and that death occurred on the date and hour stated above; immediate cause of death _____ Duration _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
ADDITIONAL INFORMATION

Major findings: About five months before her death she fell on a street in Dearborn, Michigan
Of operations _____
Of autopsies _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) No death was
(b) Date of occurrence None was due to an
(c) Where did injury occur? None (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? No
While at work? No (Specify type of place) _____ (e) Means of injury None
23. Signature M.H. Wood (M. D. or other) MD
Address Dearborn MO Date signed 4-18-46

SUPPLEMENTARY

WRITE PRINTED NAME IN BLACK INK—MAKE A PERMANENT RECORD

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3880

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