

No. 2  
5-43  
5-17-39  
I X36671

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF THE VITALS  
**FILED JUN 10 1946 STANDARD CERTIFICATE OF DEATH**

15807

State File No. \_\_\_\_\_

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 634

**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:  
Missouri Methodist Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 day  
 In this community 7 Years (Specify whether years, months or days)

**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. 2615 Olive 7  
 (If rural, give location) d  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Mrs Anna Marie Moore  
 3. (b) If veteran, name war No  
 3. (c) Social Security No. None

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month May day 30  
 year 1946 hour 10 minute 45P M.  
 21. I hereby certify that I attended the deceased from Oct 5 1945  
 to May 29 1946  
 that I last saw her alive on May 29 1946  
 and that death occurred on the date and hour stated above.

4. Sex Female / 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Henry R.  
 6. (c) Age of husband or wife if alive 42 years  
 7. Birth date of deceased March 20 1905  
 (Month) (Day) (Year)

Immediate cause of death Carcinoma of Right Lung Duration 7 months  
 Due to Carcinoma of R breast diagnosed 7/6/43 expired Oct 30, 1945 4 months  
 Due to on following symptoms of R. Lung in April 1945 2 months  
 Other conditions which palautensis was done  
 (Include pregnancy within 3 months of death)

**8. AGE:** Years Months Days If less than one day  
41 2 10 hr. min.

9. Birthplace Camp Creek Kansas /  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Housewife

Major findings: no operation **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED** **PHYSICIAN**  
 Of operations \_\_\_\_\_ Underline the cause to which death should be charged statistically.  
 Of autopsy \_\_\_\_\_

**MOTHER FATHER**  
 11. Industry or business \_\_\_\_\_  
 12. Name George W. Koehn  
 13. Birthplace Kans. /  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Caroline (Unknown)  
 15. Birthplace Kans. /  
 (City, town, or county) (State or foreign country)

16. (a) Informant H.R. Moore  
 (b) Address St Joseph, Mo.  
 17. (a) Burial (b) Date thereof 6-1-46  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Oakhill-Atchison Ks.

**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 St Joseph, Mo.  
 (b) Address \_\_\_\_\_  
 19. (a) June 5, 1946 (b) H. Westheuser  
 (Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
 (c) Means of injury ⊙  
 23. Signature Gordon D Wright M.D. (M. D. or other)  
 Address 845 So. 19th St. Joe. Mo. Date signed 5/31/46

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

1958

44-1-2

**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 Robert H. Gable

..... Licensed Embalmer No. 3308

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.**

Registration District No. A 2 Primary Registration District No. 1000

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:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Anna M. Moore  
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 M  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_  
7. Birth date of deceased Mar 2 (Month) (Day) (Year)

8. AGE: Years 41 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Kansas (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_  
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) (Specify type of place)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)  
(Date received local registrar)

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 \_\_\_\_\_

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

Probably the right breast which had been excised  
Due to carcinoma about one year and 4 months before she died. This was followed by a continuation of the disease as evidenced by metastases of the breast carcinoma throughout the lymphatic system.  
Other conditions (include pregnancy within \_\_\_\_\_ months of death) \_\_\_\_\_  
Major findings: Chiefly lymphatic and general metastases of the right breast carcinoma.  
Of autopsy status: At death the right breast was found with broken skin.  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: none  
(a) Accident, suicide, or other external cause \_\_\_\_\_  
(b) Date of occurrence: the last 7 months of the illness  
(c) Where did injury occur: at her general consulting office  
(d) Did injury occur in or about \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State) \_\_\_\_\_ (Country) \_\_\_\_\_ (Ship)  
that little could be done for her.  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature Gordon DeSigh (M. D. or other) \_\_\_\_\_  
Address 846 S. 19th St. St. Joe, Mo. Date signed 4/17/46

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

SUPPLEMENTARY

17699

15807