

S. No. 2
M-5-43
5-17-39
X36671

FILED AUG 2 1946 STANDARD CERTIFICATE OF DEATH

State File No. 22723

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 865

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 2 weeks
 In this community 50 Years
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs Juliet Comello
 3. (b) If veteran, name war No
 3. (c) Social Security No None

4. Sex Female
 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Pete Comello
 6. (c) Age of husband or wife if alive 60 years
 7. Birth date of deceased December 7 1888
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
 57 7 20 hr. min.

9. Birthplace Sedgewick Co. Kansas
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name James M. Parker

13. Birthplace Ind.
 (City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Wimp
 (City, town, or county) (State or foreign country)

15. Birthplace Not Known
 (City, town, or county) (State or foreign country)

16. (a) Informant Pete Comello

(b) Address St Joseph, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-46
 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Fleeman & Son Inc.

(b) Address St Joseph, Mo.

19. (a) July 31, 1946 (b) Registrar's 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. 3024 So. 29th
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27
 year 1946 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from
 year 1930, to July 27, 1946
 that I last saw her alive on July 27, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Myelocytic Anemia,
 Acute. Duration 4 weeks.

Due to Myelogenous Leukemia, Chronic, 5 years.

Due to
 Other conditions (include pregnancy within 3 months of death)
 1740

Major findings:
 Of operations Splenectomy 1941, Banti's Disease.
 Of autopsy Essentially negative. Diagnosis based on Hematological findings.

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature H.S. Sarnad (M. D. or other)
 Address St Joseph Mo Date signed 7-27-46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD 21586

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.