

No. 2
8-13
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29546**
Registrar's No. **1043**

FILED SEP 23 1946

Registration District No. 42 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: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hours 45 minutes
(Specify whether
In this community 2 hours 7 45 minutes
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. None
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Infant Angsten

(b) If veteran, name war No

(c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased September 13 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 2 hr. 45 min.

9. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name John Walters Angsten

13. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Thelma Jeanette Hetz

15. Birthplace Atchison Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant John W. Angsten

(b) Address 2020 Agency Road, St. Joseph, Mo.

17. (a) Burial (b) Date thereof 9/14/1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 1302 Faraon St. Joseph, Missouri

19. (a) Sept. 18, 1946 (b) J. G. Nestel
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 13th
year 1946 hour _____ minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept. 3, 1946 to Sept. 13, 1946
that I last saw her alive on Sept. 13, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Premature (5 mo)

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 J. H. Albrecht (M. D. or other) _____

Address City Date signed 9/16/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by.....

anyone....., Registered Apprentice No.....
working under my personal supervision.

Signed *Albert E. Harrington*

Licensed Embalmer No. *3298 Pms*

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.