

FILED DEC 2 1946

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **1300**

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

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:
309 E. Colorado
(If not in hospital or institution, write street number and location)
 (d) Length of stay: **one month**
In hospital or institution. (Specify whether)
Lifetime
In this community. (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. **309 W. Colorado**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No) 0
 If yes, name country.....

3. (a) PRINT FULL NAME **Amanda Boyd**
 3. (b) If veteran, name war **None**
 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Nov.** day **17th**
 year **1946** hour **7** minute **30** A.M.

4. Sex **Female** / 5. Color of race **White**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive **20, 1870** years
 7. Birth date of deceased **August 20, 1870**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 26, 1938** 19 to **10/25/46** 19;
 that I last saw him alive on **10/26/46** 19;
 and that death occurred on the date and hour stated above.
 Immediate cause of death **Cardiac Myocarditis**
 Duration **2-yrs.**

8. AGE: Years **76** Months **2** Days **27**
 If less than one day **hr. min.**

Due to.....
 Due to.....

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

Other conditions **Blindness & Chronic Bronchitis.**
(Include pregnancy within 3 months of death)

10. Usual occupation **Self - home**

Major findings:
 Of operations.....
 Of autopsy.....
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

11. Industry or business.....
 12. Name **Unknown**
 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 **Mrs. Gus Bryson (niece)**
 (b) Address **809 W. Hyde Park, City**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify).....
 (b) Date of occurrence.....

17. (a) **Burial**
(Burial, cremation, or removal)
 (b) Date thereof **11/20/46**
(Month) (Day) (Year)
 (c) Place: burial or cremation **I.O.O.F. Cemetery**

(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

18. (a) Signature of funeral director **John Pryor**
 (b) Address **6054 Pryor Ave, City**

23. Signature **Arthur J. ...** (M. D. or other) **MD**
 Address **Social Welfare Board** Date signed **11/19**

19. (a) **Nov. 25, 1946** (b) **E. C. Jenkens**
(Date received local registrar) (Registrar's signature)

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:

John E. Rupp

Licensed Embalmer No. *3986*

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.