

**FILED FEB 10 1947**

Registration District No. \_\_\_\_\_

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:  
Wellis Nursing Home 2805 Fred. Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11 days **4**  
(Specify whether Life)  
In this community Life  
years, months or days

3. (a) PRINT FULL NAME Mary E. Whalen

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, Widowed

6. (b) Name of husband or wife William Whalen  
6. (c) Age of husband or wife if alive 10 years

7. Birth date of deceased July 10 1861  
(Month) (Day) (Year)

8. AGE: Years 35 Months 6 Days 22  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation at home

11. Industry or business at home

MOTHER FATHER {  
12. Name Michael Meaney  
13. Birthplace Unknown Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Bridget O'Brien  
15. Birthplace Unknown Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Catherine Meaney  
(b) Address R.R. #4, St. Joseph, Mo.

17. (a) burial (b) Date thereof 2/5/47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director No. 1010 St. Joseph, Mo.  
(b) Address \_\_\_\_\_

19. (a) 2-6-47 (b) St. Joseph, Mo.  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Buchanan  
(c) City or town Rural Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2 1/2 miles So. of St. Joseph  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb. day 2  
year 1947 hour 11 minute 15 P. M.

21. I hereby certify that I attended the deceased from 1-20 1947 to Feb. 2 1947  
that I last saw her alive on Feb. 2 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
Duration since 1-20-47

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Arteriosclerosis (general)  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy Q3 A

**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 work) (Means of injury)

23. Signature St. Joseph, Mo.  
Address \_\_\_\_\_ Date signed 2-5-47

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

For my body.

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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, ~~only~~.....  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Eugene Wood.....

Licensed Embalmer No. 3804.....

P. O. Address. 514 50th 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.**