

No. 2
M-5-43
5-17-39
X38671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4078

FILED FEB 17 1947
Registration District No. 42

Primary Registration District No. 1000

State File No. _____
Registrar's No. 198

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:
2920 Penn Street-Nursing Home 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. Four years
Most of her life. (Specify whether)

In this community _____
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. 2920 Penn Street.
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME MARY BELLE STEVENSON.

3. (b) If veteran, No name war.

3. (c) Social Security No. None.

4. Sex Female/ 5. Color or race White

6. (a) Single, widowed, married, divorced, Widow.

6. (b) Name of husband or wife. George Stevenson-
6. (c) Age of husband or wife if alive Dec years

7. Birth date of deceased. Unknown Unknown 1864
(Month) (Day) (Year)

8. AGE: Years 83 Months ? Days ?
If less than one day ? ?
hr. ? min.

9. Birthplace Delavan, Illinois.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife.
Home.

11. Industry or business _____

MOTHER, FATHER { 12. Name Edward C. Culbertson

13. Birthplace Unknown Ohio. /
(City, town, or county) (State or foreign country)

14. Maiden name Ruth Sheats

15. Birthplace Unknown Ohio. /
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Culbertson

(b) Address Delavan, Illinois.

17. (a) Place: burial, or cremation Mt. Auburn Cemetery
(Burial, cremation, or removal)

(b) Date thereof Feb. 12, 1947
(Month) (Day) (Year)

18. (a) Signature of funeral director Mrs. E. P. Sidenfaden
(b) Address 602 South 10th. Street

19. (a) 2-12-47 (b) K. B. Jenkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb- 10th. (MON)
day 6 year 1947 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from Feb 8, 1947 to Feb 10, 1947
that I last saw her alive on Feb 8, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death. Cerebral Hemorrhage 2 days
Due to H.B.P.
Due to _____

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

Major findings: Of operations _____
Of autopsy _____

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 R. Elliott M.D. or other _____
Address 80 W. Drovers St. Joplin Mo Date signed 2-10-47

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 *Mollie E. Sidenfaden Fox*

Licensed Embalmer No. *4235*

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. †