

FILED JUN 2 1947

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

16531

State File No. _____

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 681

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: St. Joseph's Hosp?
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 hr - 20 min
 (Specify whether
 In this community 1 hr - 40 min
 years, months or days)

3. (a) PRINT FULL NAME

Infant Girl Brown

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Female 5. Color or race W. 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 5-24-47
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>00</u>	<u>00</u>	<u>00</u>	<u>1 hr. 40. min.</u>

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

10. Usual occupation New born

11. Industry or business _____

12. Name Albert Brown

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

14. Maiden name Grace Ellen Bingham

15. Birthplace New York (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Grace Brown

(b) Address R R # 1, St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27, 1947
 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Halls Meierhoffer

(b) Address 1046 Colhoun St., St. Joseph, Mo.

19. (a) May 24, 1947 (State received local registrar) (b) H. L. Jenkins (Including a signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph, rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Newborn #4
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24
 year 1947 hour 3:40 minute 0 P. M.

21. I hereby certify that I attended the deceased from 2 pm 5-24 1947 to 3:40 pm 1947
 that I last saw her alive on 5-24-47, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia neonatorum 14 Mo.
Premature -

Due to Placental apoplexy - (mother)

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) (r) Means of injury _____

23. Signature Felix Vardigan (M. D. or other) 1947
 Address 620 Homer Date signed _____

Duration 14 Mo.
 Underline the cause to which death should be charged statistically.

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

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 Albert C. Harrington

Licensed Embalmer No. 3258 Mo

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.