

S. No. 2
DM-5-43
v. 5-17-39
1 X38671

FILED SEP 22 1947
Registration District No. 42

Primary Registration District No. 1000

State File No. _____
Registrar's No. 1104

1. PLACE OF DEATH:
(a) County Beechman
(b) City or town St Joseph
(c) Name of hospital or institution:
627 South 18th St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 26 yrs
In this community 26 yrs
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Beechman
(c) City or town St Joseph, MO
(d) Street No. 627 South 18th St
(If outside city or town limits, write "RURAL" and name of township)
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME DOLLIE-B-DEVARY
(b) If veteran, name war no
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 11
year 1947 hour 10:10 minute a. M.
21. I hereby certify that I attended the deceased from SEPTEMBER 9
1947, to SEPTEMBER 10 1947;
that I last saw h. ER alive on SEPT 10 1947;
and that death occurred on the date and hour stated above.

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 March 6 1874
(Month) (Day) (Year)

Immediate cause of death CHRONIC INTERSTITIAL NEPHRITIS Duration 5 YRS.
Due to UNKNOWN

8. AGE: Years 73 Months 6 Days 5
If less than one day hr. min.

Due to _____
Other conditions PROLAPSE UTERUS 15 YRS.
(Include pregnancy within 3 months of death)

9. Birthplace Winchester Ky.
(City, town, or county) (State or foreign country)
10. Usual occupation at home

Major findings: Of operations none
Of autopsy none 131P
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name John R. DeVary
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Jones
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph E. DeVary
(b) Address St Joseph Mo

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(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? _____

17. (a) REMOVED (b) Date thereof April 13-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation alta vesta mo

While at work? _____ (Specify type of place) (e) Means of injury 0

18. (a) Signature of funeral director Alma Funeral Home
(b) Address St Joseph Mo
19. (a) 9-15-47 (b) B. B. Jenkins
(Date received local registrar) (Registrar's signature)

23. Signature Allen Siderman (M. D. or other) MD
Address 1302 Faragon Date signed 9/12/47

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.....

Charles M. Harman....., Registered Apprentice No. *450*

working under my personal supervision.

Signed.....

John Ray Stoney

Licensed Embalmer No. *2435*

P. O. Address *St. Joseph*

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.