

No. 2
1747
17-39

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED JAN 19 1948

Registration District No. 22

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

44147

State File No.

Primary Registration District No. 1000

Registrar's No. 1564

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: McKernan Nursing Home 1313 No. 10th
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether
In this community 30 years
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. 1122 So. 16th
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Delia Sexton

3. (b) If veteran, name war none

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 Willis Sexton

6. (c) Age of husband or wife if alive years

7. Birth date of deceased November 3 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
✓	82	1	24	hr. min.

9. Birthplace unknown Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business At home

12. Name unknown Yates

13. Birthplace unknown Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name unknown

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

16. (a) Informant W. J. Sexton
(b) Address 429 West 11th St. Kansas City, Mo.

17. (a) burial (b) Date thereof 12/29/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director: Neaton - Bowman
(b) Address St. Joseph, Mo.

19. (a) 1-14-48 (b) G. B. Jenkins
(Date received local registrar) (Registrar's Signature)

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 27
year 1947 hour 5 minute P M.

21. I hereby certify that I attended the deceased from December 23 1947 to December 27 1947
that I last saw her alive on December 23 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis
Duration 4 days

Due to Arteriosclerosis 10 yrs.

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operation

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? (Specify type of place)

While at work? (e) Means of injury

23. Signed Charles H. Kernery, M.D.
Address 221 Kirkpatrick Bldg., St. Joseph, Mo. Date 12-29-1947

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

MOTHER: FATHER:

PHYSICIAN

Underline the cause of which death should be charged statistically.

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.....

Eugene Wood

Licensed Embalmer No. *3804*

P. O. Address.....

3195.1st St. 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.