

FILED MAR 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4054**

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>235</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>42 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1920 Delmar</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>EFFIE</u>		b. (Middle) <u>BELL</u>		c. (Last) <u>COHENOUR</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 24 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>July 23, 1879</u>	
9. AGE (In years last birthday) <u>69</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaking</u>		11. BIRTHPLACE (State or foreign country) <u>Davis City, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME (1st unknown) <u>Burrell</u>			13b. MOTHER'S MAIDEN NAME <u>Artle West</u>			14. NAME OF HUSBAND OR WIFE <u>Melvin Cohenour</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Letha Cohenour 1920 Delmar, St. Joseph</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>AT cerebral hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>5 yrs</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>450</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Feb 22, 1949</u> , to <u>Feb 24, 1949</u> , that I last saw the deceased alive on <u>Feb 24, 1949</u> , and that death occurred at <u>12:45 P m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>J. J. Ryan M.D.</u>				23b. ADDRESS <u>301 N 8 - St. Joseph, Mo.</u>		23c. DATE SIGNED <u>2-26-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 26, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Public Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 28, 1949</u>		REGISTRAR'S SIGNATURE <u>E. C. Jenkins</u>		3820 FUNERAL DIRECTOR'S SIGNATURE <u>Earl Clark</u>		ADDRESS <u>120 Illinois Ave. St. Joseph, Mo.</u>	

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

Dr. Ryan

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed *Fred D. Clark*

Signed _____
Student Embalmer

Licensed Embalmer No. 4239

P. O. Address 120 Illinois, 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.