

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **39853**

1425

FILED DEC 27 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b> <b>0117</b>	
c. LENGTH OF STAY (in this place) <b>45 yrs.</b>		d. STREET ADDRESS (If rural, give location) <b>1003 N. 22nd Street</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1003 N.22nd Street</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Josephine</b>	b. (Middle) <b>May</b>	c. (Last) <b>Fox</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>December 16, 1950</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 27, 1871.</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 4 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Rochester, Minn.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>I. James Daniels</b>	13b. MOTHER'S MAIDEN NAME <b>Amanda -Unknown-</b>	14. NAME OF HUSBAND OR WIFE <b>Charles D. Fox</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Charles D. Fox</b>	ADDRESS <b>St. Joseph, Missouri.</b>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		<b>few minutes</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension</b>		<b>Several years</b>
DUE TO (c) _____			<b>331X</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Arterio Sclerosis General</b>			<b>?</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from June 1, 1950 to Dec 16, 1950, that I last saw the deceased alive on 12-6-, 1950, and that death occurred at 1:30P m., from the causes and on the date stated above.

23a. SIGNATURE <b>T. L. Howden M.D.</b> (Degree or title)	23b. ADDRESS <b>ST. JOSEPH, MO. 419 Kirkpatrick Bldg</b>	23c. DATE SIGNED <b>12-18-50</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial (1)</b>	24b. DATE <b>Dec. 19, 1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Ashland Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri.</b>
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DATE REC'D BY LOCAL REG. <b>Dec 21, 1950</b>	REGISTRAR'S SIGNATURE <b>Carl C. Castillo</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Heierhoffer</b>	ADDRESS <b>St. Joseph, Mo.</b>
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(Licensed Emballer's Statement on Reverse Side)

WRITE PLAINLY—USING 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\*\*\*\*\*

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working under my personal supervision.

Student Embalmer No.....\*\*\*\*\*

Signed.....\*\*\*\*\*  
Student Embalmer

Signed.....

*Raymond W. Hershner*  
Licensed Embalmer No.....4413 Missouri

P. O. Address.....St. Joseph, Missouri.

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.