

FILED FEB 11 1946
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Registration District No. Primary Registration District No. 1000 Registrar's No. 51

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

1. PLACE OF DEATH:

(a) County Dickinson

(b) City or town St. Joseph, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution State Hospital # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 1/2 mos
6 days (Specify whether
In the community 5 yrs. 11 mos. 6 days
years, months, days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Andrew

(c) City or town Rosendale Mo
(If outside city or town limits, write "RURAL")

(d) Street No. Rural
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Gertrude Beaty

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife William E

6. (c) Age of husband or wife if alive — years (Specify whether
Date of death 17 1859 (Month) (Day) (Year)

7. Birth date of deceased 17 1859 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>86</u>	<u>0</u>	<u>26</u>	hr. min.

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

10. Usual occupation House work

11. Industry or business at home

12. Name not given

13. Birthplace in Ind (City, town, or county) (State or foreign country)

14. Maiden name not given

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

16. (a) Informant Maurice J. Wellen

(b) Address Rosendale Mo

17. (a) burial (b) Date thereof 1-17-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah Mo

18. (a) Signature of funeral director E. C. Brest

(b) Address Savannah Mo

19. (a) Jan. 14, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 1/3 day 5 year 1946 hour 5 minute 45 a.m.

21. I hereby certify that I attended the deceased from Nov 1st 1945 to Jan 1st 1946
that I last saw her alive on Jan 13 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Septic pneumonia
labor right lung 3 days
arterio-sclerosis 5 yrs

Due to arterio-sclerosis 5 yrs

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 100

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)

(a) (b) Means of injury

23. Signature [Signature] (M. D. or other) M.D.

Address St. Joseph Hospital Date signed 1/14/46

PHYSICIAN

Underline the cause to 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.....

E. C. Breit

Licensed Embalmer No.....

2650

P. O. Address.....

Savannah 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.