

FILED JUL 5 1945

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 682

1. PLACE OF DEATH

(a) County Madison

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

(c) Name of hospital or institution St. Joseph Hosp #1
(If not in hospital or institution, write street number or location) 2

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 7 yrs 10 mo 3 da
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

(c) City or town Hale
(If outside city or town limits, write "RURAL") 7

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

(e) Citizen of foreign country? _____ (Yes or No) (P)

If yes, name country _____

3. (a) PRINT FULL NAME Mary E Hoy

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race M. 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife Mr. (Dr.) Hoy 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 22 1855
(Month) (Day) (Year)

8. AGE: Years 90 Months 5 Days 0 If less than one day _____ hr. _____ min.

9. Birthplace Mo (City, town, or county) _____ (State or foreign country) 1

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Mrs. A. Singleton

13. Birthplace Mo (City, town, or county) _____ (State or foreign country) 1

14. Maiden name Julia Adams

15. Birthplace Mo (City, town, or county) _____ (State or foreign country) 1

16. (a) Informant Dr. Hoy (b) Address St. Joseph, Mo

17. (a) Removal (b) Date thereof 6-23-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director [Signature]

(b) Address [Address]

19. (a) 6-23-45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22
year 1945 hour 7 minute 00 M.

21. I hereby certify that I attended the deceased from June 1 1945 to June 22 1945
that I last saw her alive on June 22 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia

Due to Cardiac decompensation

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 950

Duration 2 day

Underline the cause to which death should be charged statistically.

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) _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address St. Joseph, Mo Date signed [Date]

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

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JUN 4 1946

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 *Clifford W. Austin*
Licensed Embalmer No. *3233*

P. O. Address *Lea, 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.