

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29979**

Registration District No. **875**

Primary Registration District No. **6162**

Registrar's No. **208**

1. PLACE OF DEATH:
 (a) County Wagon Wash, Ind
 (b) City or town Marion
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: State Hosp # 3
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day
 (Specify whether
 In this community Same
 years, months or days) 211

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Bates
 (c) City or town Butler
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Mrs. Leathern Wendleton
 8. (b) If veteran, name war No 8. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Robert Wendleton 6. (c) Age of husband or wife if alive unknown years
 7. Birth date of deceased unknown 1883
 (Month) (Day) (Year)

8. AGE: Years 55 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Kansas - Miami County
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
 { 12. Name Lewis Long
 13. Birthplace Perm.
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Charlot Hamilton
 15. Birthplace Michigan
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nellie Simonson
 (b) Address 107 E. Carlton - Pittsburg, Kan.
 17. (a) Burial (b) Date thereof 8-17-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation State Hospital Cemetery
 18. (a) Signature of funeral director Allen V. Hays
 (b) Address Nebraska, Mo
 19. (a) 8-19-40 (b) Allen V. Hays
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Aug day 8
 year 1940 hour 8 minute 20 P M.

21. I hereby certify that I attended the deceased from Aug 7
 1940, to Aug 8 1940
 that I last saw 2 alive on Aug 8 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death
Maniacal epirhastion
 Due to Manic depressive psychosis
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) GH

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy No pathological findings
 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?
795 (Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature Wm. J. Crane (M. D. or other) _____
 Address Marion Date signed 8/17/40

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

RECEIVED

District Health Officer No. 7,

District File Number 9-40-1260

Date Filed 9-4-40

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.....

Licensed Embalmer No.

P. O. Address.....

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, above space should be left blank.