FILED FEB 18 1941

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4709

Registration District No. 875 Primary Registration District No. 6162 Registrar's No. 8

1. PLACE OF DEATH:

(a) County VERNON

(b) ~~City or town~~ NEVADA

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: STATE HOSPITAL No 3

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution

In this community 5 years 1 month 26 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CASS 108

(c) City or town HARRISONVILLE 0

(If outside city or town limits, write "RURAL")

(d) Street No. UNKNOWN 0

(If rural, give location)

(e) If foreign born, how long in U. S. A.? UNKNOWN years.

3. (a) PRINT FULL NAME NANCY ROBINSON.

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife UNKNOWN

6. (c) Age of husband or wife if alive DECEASED years

7. Birth date of deceased UNKNOWN (Month) (Day) (Year)

8. AGE: Years about 76 | Months – | Days – | If less than one day – hr. – min.

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

10. Usual occupation NONE

11. Industry or business NONE

MOTHER FATHER

12. Name UNKNOWN

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

14. Maiden name UNKNOWN

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

16. (a) Informant RECORDS STATE HOSP No 3.

(b) Address NEVADA, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/41 (Month) (Day) (Year)

(c) Place: burial or cremation Harrisonville, Mo

18. (a) Signature of funeral director Fry Funeral Home

(b) Address Nevada, Mo

19. (a) 1-9-41 (Date received local registrar) (b) Allen V. Hays (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 8 year 1941 hour 7:45 minute A M.

21. I hereby certify that I attended the deceased from Oct, 1939, to JAN 8, 1941; that I last saw HER alive on JAN 8, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death CHRONIC MYOCARDITIS	
Due to ARTERIOSCLEROSIS	
SENILE PSYCHOSIS.	
Due to FRACTURE LEFT FEMOR AT ITS LOWER THIRD.	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations NONE

Of autopsy NONE

PHYSICIAN — 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) FALL ON WARD

(b) Date of occurrence DEC 24 1940.

(c) Where did injury occur? STATE HOSP No 3. NEVADA. MO (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? on WARD - FALL (Specify type of place)

While at work? NO (e) Means of injury FRACTURE LEFT FEMOR

23. Signature Paul L. Barone (M. D. or other) MD

Address State Hosp No 3 Date signed JAN 8 1941

(Licensed Embalmer's Statement on Reverse Side) Nevada Mo

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

RECEIVED
District Health Officer No. 7,
District File Number 2-41-210
Date Filed 2-5-41

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 Lloyd R. Winscott
Licensed Embalmer No. 3857
P. O. Address Nevada, 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, above space should be left blank.