

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

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 12 DAYS  
(Specify whether  
In this community YES  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County BARTON  
(c) City or town LAMAR  
(If outside city or town limits, write "RURAL")  
(d) Street No. UNKNOWN  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? U.S.A. 0 years.

3. (a) PRINT FULL NAME ANGELINE SPOON  
(b) If veteran, name war None  
(c) Social Security No. UNKNOWN

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 25  
year 1941 hour 8 minute A M.  
21. I hereby certify that I attended the deceased from  
MARCH 13, 1941, to MARCH 25, 1941;  
that I last saw her alive on MARCH 25, 1941;  
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOW  
7. (b) Name of husband or wife UNKNOWN 6. (c) Age of husband or wife if alive UNKNOWN years  
7. Birth date of deceased UNKNOWN  
(Month) (Day) (Year)

Immediate cause of death  
CHRONIC DEGENERATIVE MYOCARDITIS

8. AGE: Years 76 Months - Days - If less than one day - hr. - min.

Due to CARDIO-VASCULAR RENAL DISEASE (CHRONIC MYOCARDITIS, CHR NEPHRITIS-GEN ARTERIOSCLEROSIS)

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

Other conditions (include pregnancy within 3 months of death)  
SENILE DEMENTIA - AGITATED

10. Usual occupation HOUSEWIFE

Major findings Of operations NONE Of autopsy NONE

11. Industry or business NONE

MOTHER FATHER { 12. Name SAMUEL LAYMAN  
13. Birthplace UNKNOWN KENTUCKY  
(City, town, or county) (State or foreign country)  
14. Maiden name ELIZA JANE COLTER  
15. Birthplace UNKNOWN UNKNOWN  
(City, town, or county) (State or foreign country)

PHYSICIAN TYPE  
Underline the cause to which death should be charged statistically.

16. (a) Informant RECORDS - STATE HOSPITAL 3  
(b) Address NEVADA - MO.

22. If death was due to external causes, fill in the following: NO

17. (a) Removal (b) Date thereof Mar. 25 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

(c) Place: burial or cremation \_\_\_\_\_

(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 \_\_\_\_\_

18. (a) Signature of funeral director Leslie J. Subford  
(b) Address Lamar

23. Signature Paul L. Barone (M. D. or other) D  
Address STATE HOSPITAL No 3 Date signed MARCH

19. (a) 3-25-41 (b) Allen Hays  
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 7,

District File Number 4-41-634

Date Filed 4-8-41

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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 Lester S. Hubbard

Licensed Embalmer No. 3530

P. O. Address Lawson, 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.