

No. 2
1-13-40
-17-39
X2315

FILED SEP 10 1941 85

Registration District No. _____

Primary Registration District No. 1001

Registrar's No. 827

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

1. PLACE OF DEATH **BUCHANAN**
 (a) County **BUCHANAN**
 (b) City or town **ST. JOSEPH**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **STATE HOSPITAL No. 2**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **74 ds.**
 (Specify whether
 In this community
 years, months or days)

3. (a) PRINT FULL NAME **Lillian Wathen**
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex **female** 5. Color or race **white**
 6. (a) **single** widowed, married, divorced, **wid.**
 6. (b) Name of husband or wife **Henry Wathen**
 6. (c) Age of husband or wife if alive **3** years
 7. Birth date of deceased **May 1960**
 (Month) (Day) (Year)

8. AGE: Years **81** Months **3** Days **13**
 If less than one day hr. min.

9. Birthplace **Dariness Co. Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **house wife**

11. Industry or business _____

12. Name **Benj. Downs**

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

14. Maiden name **Elizabeth Horman**

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

16. (a) Informant **Mr. Nell York**

(b) Address **5316 Sawyer St. St. Joseph**

17. (a) **Removal** (b) Date thereof **8-9-41**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Winston, Mo.**

18. (a) Signature of funeral director **Kate Stroup**

(b) Address **14 Winston, Mo.**

19. (a) **8/16/41** (b) **J. J. Nestel**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Buchanan**
 (c) City or town **St. Joseph**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **5316 Sawyer**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **16**
 year **1941** hour **7-30** minute **0** M.

21. I hereby certify that I attended the deceased from **July 23**, 19**41**, to **Aug. 16**, 19**41**;
 that I last saw her alive on **Aug. 16**, 19**41**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **broncho pneumonia**
 Duration **1 w.**

Due to _____

Due to **107**

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 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 **T. J. O'Sell** (M. D. or other) **J. M. D.**
 Address **St. Joseph** Date signed **8/16/41**

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

Walter V. Stroup

Licensed Embalmer No. *4074*

P. O. Address *Winston*

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.