

JAN 13 1942

State File No.

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 357

1. PLACE OF DEATH:

(a) County Vernon  
(b) City or town Washington Jan Ship  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
State Hospital Nevada, Mo  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 Mo 9 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sr Clair  
(c) City or town Appleton City  
(If outside city or town limits, write "RURAL")  
(d) Street No. Hubman  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19th  
year 1941 9 hour \_\_\_\_\_ minute A. M.

21. I hereby certify that I attended the deceased from Jan 31/25  
~~Dec 1941~~ 1941 to Dec 1941 1941;  
that I last saw him alive on Dec 18th 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Senile Psychosis

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Gen. Arterio Sclerosis  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 1620

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 G.S. Warwick (M. D. or other) \_\_\_\_\_  
Address State Hospital Nevada Date signed 12/19/41

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

3. (a) PRINT FULL NAME Amaziah H. DEWEESE

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 28th 1857  
(Month) (Day) (Year)

8. AGE: Years 83 Months 11 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name JESS DEWEESE

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

14. Maiden name Hubman

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

16. (a) Informant Wash. Records

(b) Address State Hosp #3 Nevada Mo

17. (a) Burial (b) Date thereof Dec 21 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Appleton City Mo

18. (a) Signature of funeral director W. Oscar Eckhoff

(b) Address Appleton City Mo

19. (a) Dec 19 1941 (b) Allen D. Koser  
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 7,

District File Number 12-41-2116

Date Filed 1-7-42

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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 *Oscar Edhoff*

Licensed Embalmer No. 3942

P. O. Address *Appleton City, Wn*

**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.**