

FILED DEC 30 1942
Registration District No. 12

Primary Registration District No. 1008

Registrar's No. 1201

1. PLACE OF DEATH:

(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 of institution, write street number or location)
(d) Length of stay: In hospital or institution 17 mo - 14 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston!
(c) City or town Chillicothe
(If outside city or town limits, write "RURAL")
(d) Street No. 7
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME

Mary Schwab

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 Widow
6. (b) Name of husband or wife Deceased
6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased 7 - 12 - 1859
(Month) (Day) (Year)

8. AGE: Years 83 Months 5 Days 3
If less than one day hr. min.

9. Birthplace Unknown Missouri!
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business.....

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. J. W. Kincaid
(b) Address P.O. Box 5, Hamilton, Missouri

17. (a) Removal (b) Date thereof 12 - 15 - 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chillicothe, MO

18. (a) Signature of funeral director Norman & Son
(b) Address Chillicothe, MO.

19. (a) 12 - 15 - 42 (b) Rose Heigoy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 15
year 1942 hour 9:45 minute A. M.

21. I hereby certify that I attended the deceased from November 28
1942, to December 15, 1942,
that I last saw her alive on December 15, 1942,
and that death occurred on the date and hour stated above.

Immediate cause of death:
Bronchial Pneumonia
after surgery

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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 0
23. Signature R. D. Sweary M. D. or other MD
Address State Hospital # 2 Date signed 12-15-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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. 3308

P. O. Address St. Joseph 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, fact should be so stated above.