

1-5-42
5-17-39
X32873

FILED JAN 11 1943

Registration District No. 3076

Primary Registration District No. _____

Registrar's No. _____

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 Hosp No 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community one year 6 mo 2 & days (Specify whether
years, months or days)

3. (a) PRINT FULL NAME MARY-DIETRICH

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 single

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 6 1879
(Month) (Day) (Year)

8. AGE: Years 63 Months 6 Days - If less than one day _____ hr. _____ min

9. Birthplace Cooper County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation housework

11. Industry or business none

12. Name Frank Dietrich

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

14. Maiden name Maria Krause

15. Birthplace Cooper County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hosp No 3

(b) Address Nevada Missouri

17. (a) Burial (b) Date thereof Jan 8 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph Shrine Kansas

18. (a) Signature of funeral director Edna Leland

(b) Address 1901 Atlantic Blvd S.C.A.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2816 Olive St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 6
year 1943 hour 5 minute 00 A.M.

21. I hereby certify that I attended the deceased from June 13; 1941, to Jan 6, 1943
that I last saw her alive on Jan 6, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris

Due to Coronary Sclerosis

Other conditions Dementia Precox
(Include pregnancy within 3 months of death)

Major findings: Of operations none performed

Of autopsy none performed

22. If death was due to external causes, fill in the following: No
(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?
Kansas (Specify type of place) _____ (e) Means of injury _____

23. Signature Paul L Barone (M. D. or other) _____
Address State Hosp No 3 Date signed Jan 6 1943

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

MOTHER FATHER

Physician
Underline the cause to which death should be charged statistically.

1-6-43

I hereby authorize the removal of body of
Mary Dabnick from State Hospital to
Cemetery in Kansas City, Mo.
W. D. [Signature]
State Officer

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..... [Signature]

Licensed Embalmer No. 3991

P. O. Address 309 E 67 St
KCMO

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.

STANDARD CERTIFICATE OF DEATH

State File No. 42282

Registration District No. 360 Primary Registration District No. 3076 Registrar's No.

1. PLACE OF DEATH:
(a) County: Vernon
(b) City or town: Nevada
(c) Name of hospital or institution: State Hosp No 3
(d) Length of stay: In hospital or institution
In this community: 1 up to mo 2 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: mo (b) County: Jackson
(c) City or town: Manassas
(d) Street No.: 2816 Shuif
(e) Citizen of foreign country? (Yes or No) _____
If yes, name country: _____

3. (a) PRINT FULL NAME: Mary Dietrich
(b) If veteran, name war: _____ (c) Social Security No.: _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: 1943 month Jan day 6 hour 10:00 minute AM
21. I hereby certify that I attended the deceased from Jan 6 1943 to Jan 6 1943
that I last saw him/her alive on Jan 6 1943
and that death occurred on the date and hour stated above.
Immediate cause of death: Angina Pectoris Duration _____

4. Sex: F 5. Color or race: W 6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife: _____ 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: July 6 1943
(Month) (Day) (Year)
8. AGE: Years 63 Months 6 Days 6 If less than one day _____ min.

9. Birthplace: Manassas, mo
(City, town, or county) (State or foreign country)
10. Usual occupation: Supervisor
11. Industry or business: None

12. Name: Frank Dietrich
13. Birthplace: France
(City, town, or county) (State or foreign country)
14. Maiden name: Mrs. Krane
15. Birthplace: Laager, mo
(City, town, or county) (State or foreign country)

16. (a) Informant: Records State Hosp No 3
(b) Address: Nevada, mo
17. (a) Burial (b) Date thereof: Jan 8 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: St. Joe Cem. Shawnee Kan.

18. (a) Signature of funeral director: State Funeral Home
(b) Address: 1901 State Blvd. K.C.
19. (a) (2-5-43) (b) Rayl B. Benick
(Date received local registrar) (Registrar's signature)

Due to: Coronary Sclerosis
Due to: _____
Other conditions: Dementia Precoc
(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) (c) Means of injury: _____
23. Signature: Paul L. Barone (M. D. or other) _____
Address: State Hosp # 3 Date signed: 1-6-43
nevada, mo

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

MOTHER FATHER

DEATH CERTIFICATE

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

Center
Wash
Badger.