

FILED MAY 3 1943

Registration District No. 42

Primary Registration District No. 1000/001

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 # 29.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 17-7 min 3 days  
(Specify whether  
In this community Yes  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Kansas City Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country A

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31  
year 1943 hour 2 minute P M.

21. I hereby certify that I attended the deceased from Jan 19 1943 to Mar 31 1943  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pericardial hemorrhage suddenly

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

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

Other conditions (Include pregnancy within 3 months of death) 83a!

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 \_\_\_\_\_

23. Signature [Signature] (M. D. or other)  
Address State Hospital # 2 Date signed April 1, 1943

3. (a) PRINT FULL NAME Jessie May Lewis

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 70

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced, widower divorced widower

6. (b) Name of husband or wife not given 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 12-29-1888  
(Month) (Day) (Year)

8. AGE: Years 54 Months 3 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House wife

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

12. Name Ruben Warner

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

14. Maiden name Mary A. Mitchell

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

16. (a) Informant Records

(b) Address State Hospital #

17. (a) Burial (b) Date thereof 4-2-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City Kansas

18. (a) Signature of funeral director [Signature]

(b) Address Kansas City Kansas

19. (a) 4-2-43 (b) Rose Hergoy  
(Date received local registrar) (Registrar's signature)

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

April 1, 1943

SEP 22 1943

FEB 9 1944

AUG 17 1943

JUL 18 1944  
JUL 21 1944

**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 \_\_\_\_\_

working under my personal supervision. \_\_\_\_\_  
Registered Apprentice No. \_\_\_\_\_

Signed *Robert R. Gable*

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.**