

AUG 26 1949 360

Registration District No. ~~360~~

Primary Registration District No. 6225

Registrar's No. 125

FILED

108
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County CORNER Vernon
 (b) City or town Nevada Washington Twp
 (c) Name of hospital or institution: State Hospital # 2 2
 (d) Length of stay: In hospital or institution 6 mo. 4 days
 In this community 6 mo. 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
 (c) City or town Springfield
 (d) Street No. _____
 (e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Josie Marigny

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W.
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Paul P. 6. (c) Age of husband or wife if alive ? years
 7. Birth date of deceased June 30 1878

8. AGE: Years 65 Months 2 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Kolla Missouri

10. Usual occupation None (Patient)

11. Industry or business None

MOTHER FATHER

12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. (a) Informant Hospital Record

17. (a) Burial (b) Date thereof 7/18/43
 (c) Place: burial or cremation Hazelwood Cemetery

18. (a) Signature of funeral director Wm. C. Greene
 (b) Address 1100 Boonville Ave. Joplin Mo.

19. (a) 8-10-43 (b) Hoel B. Seuerck
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16th year 1943 hour 11 minute 45 AM.

21. I hereby certify that I attended the deceased from February 1, 1943 to July 16, 1943; that I last saw her alive on July 16, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerosis
Acute Myocardium

Due to _____
 Due to 920
 Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations None
 Of autopsy None

Duration _____
 PHYSICIAN _____
 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) No
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 Means of injury C

23. Signature R.B. Lester (M.D. or other) _____
 Address Stat. Hosp. No. 3 Nevada Mo. date signed 7-16-43

AUG 26 1943

RECEIVED
District Health
District File Number 8-24-43
Date Filed
CHICAGO No. 21
7-13-43

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 *F. C. Thome*

Licensed Embalmer No. *2899*

P. O. Address *Springfield, Miss*

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.