

FILED JUL 19 1944  
Registration District No. 2558

Primary Registration District No. 2558

1. PLACE OF DEATH:

(a) County Haskell

(b) City or town Pomona  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Haskell  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Haskell

(c) City or town Pomona  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Catherine M. Hight

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 27  
year 44 hour 9 minute 00 A.M.

21. I hereby certify that I attended the deceased from 6-15-40 to 5-27-44

4. Sex F

5. Color or race Wht

6. (a) Single, widowed, married, divorced W. D.

6. (b) Name of husband or wife J. H. Hight

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

7. Birth date of deceased: 2 (Month) 9 (Day) 1868 (Year)

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years 76 Months 2 Days 18  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Carcinoma of Cervix Duration 5 yrs.

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

Due to Asa

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace: \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

Major findings: Biopsy showed epidermoid carcinoma

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

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

12. Name: unk

13. Birthplace: \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace: \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss M. H. Clemmons

(b) Address 1244 E. 1st St. Pl.

17. (a) \_\_\_\_\_ (b) Date thereof: 5 29 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Washburn

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? \_\_\_\_\_

18. (a) Signature of funeral director: Washburn

(b) Address: West Plains, Mo.

19. (a) 6-12-44 (b) Thelma Ferguson  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury: \_\_\_\_\_

23. Signature: C. Callahan (M. D. or \_\_\_\_\_)

Address: Willow Springs Date signed: 6/10/44

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

6  
0  
0

RECEIVED

District Health Officer No. 5,

District File Number 744389

Date Filed 7-8-44

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 D. H. Robertson

Licensed Embalmer No. 3432

P. O. Address West Plains, 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.