

FILED NOV 8 1944

Registration District No. 220

Primary Registration District No. 6225

Registrar's No. 162

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Nevada Washington Twp.  
(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 3 years 9 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates

(c) City or town Rockaville 107  
(If outside city or town limits, write "RURAL")

(d) Street No. unknown  
(If rural, give location)

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

3. (a) PRINT FULL NAME CHARLE Y-WHITE

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex 0 male

5. Color or race white

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

6. (b) Name of husband or wife Kate White

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased Sept 23 1869  
(Month) (Day) (Year)

8. AGE: Years 75 Months 0 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation formerly farmer

11. Industry or business none

12. Name N. White

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 Records State Hosp

(b) Address Nevada, Mo.

17. (a) Removal (b) Date thereof Oct 1 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Leath Kansas

18. (a) Signature of funeral director Henry Funeral Home

(b) Address Nevada Mo.

19. (a) 10-2-44 (b) Hazel B. Beumck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1  
year 1944 hour 6 minute 15 P M.

21. I hereby certify that I attended the deceased from Sept 22, 1944, to Oct 1, 1944  
that I last saw him alive on Oct 1, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Degenerative myocarditis

Due to arteriosclerosis & hypertension

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

Other conditions Extensive Cancer - right side of face - schizophrenia  
(Include pregnancy within 3 months of death)

Major findings PHYSICIAN

Of operations none

Of autopsy none

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? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

23. Signature Paul L. Barone (M. D. or other)

Address State Hosp No 3 Date signed Oct 1, 1944

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

800

RECEIVED

Dir

Office: R. Z.

10-94-1246

11-7-44

Date filed

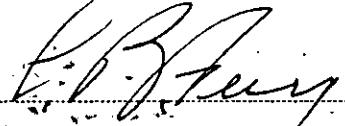
**STATEMENT BY LICENSED EMBALMER**

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. ....

1760

P. O. Address.....

Florida 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.**