

FILED DEC 20 1944

Registration District No. **72** Primary Registration District No. **1000** Registrar's No. **1244**

1. PLACE OF DEATH:

(a) County **St. Joseph**

(b) City or town **St. Joseph Mo**
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution **7 yrs 8 mos 13 ds**
(Specify whether years, months or days)

In this community **Yes**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Lettis**

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

(d) Street No. **7**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **U**

3. (a) PRINT FULL NAME **Anna Tillie**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov 30** day **30**
year **1944** hour **2 50** minute **P** M.

4. Sex **Female**

5. Color or race **colored**

6. (a) Single, widowed, married, divorced **never**

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive **1** years

7. Birth date of deceased **not given**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Jan 1** 19**44** to **Nov 30** 19**44**
that I last saw **her** alive on **Nov 30** 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hy postatic pneumonia**
Duration **1 day**

8. AGE:	Years	Months	Days	If less than one day
	66	1	?	hr. min.

Due to **Paresis? not unclassified after admission**

9. Birthplace **not given**
(City, town, or county) (State or foreign country)

Due to _____

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

10. Usual occupation **domestic**

11. Industry or business _____

12. Name **not given**

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

14. Maiden name **"**

15. Birthplace **"**
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: Of operations **30**

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant **State Hospital records**

(b) Address **St. Joseph Mo**

17. (a) **Burial** (b) Date thereof **12-4-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sedalia Mo**

18. (a) Signature of funeral director **F. B. Ferguson**

(b) Address **Sedalia**

19. (a) **12/4/44** (b) **Walter P. Reckle**
(Date received local registrar) (Registrar's signature)

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 **B. B. Cassens** (M. D. or other)
Address **State Hospital, Mo** Date signed **12/19/44**

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

MOTHER FATHER

JAN 17 1968

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. D. Figueroa

Licensed Embalmer No. 2172

P. O. Address Sedalia

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.