

Registration District No. 360

Primary Registration District No. 6225

State File No. \_\_\_\_\_

Registrar's No. 38

1. PLACE OF DEATH: Vernon

(a) County Vernon

(b) City or town Rural Washington Twp.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp. No 32  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mo. 3 da (Specify whether  
In this community Same time years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Greene Co. Home  
(If outside city or town limits, write "RURAL") 108

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Harriett Paine

3. (b) If veteran, name war No

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. 23 day 1945  
year \_\_\_\_\_ hour 7 minute A. M.

21. I hereby certify that I attended the deceased from Feb. 20-45  
\_\_\_\_\_, 19\_\_\_\_, to Feb. 23 - 19\_\_\_\_.

4. Sex Fem. 5. Color White race \_\_\_\_\_

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased Apr. 23 - 1865  
(Month) (Day) (Year)

that I last saw her alive on 2-22-45, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Dilatation Duration \_\_\_\_\_

8. AGE: Years 79 Months 10 Days 0 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to Chronic Myocarditis

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

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

10. Usual occupation None

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

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

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

MOTHER FATHER { 12. Name no history \_\_\_\_\_

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

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

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

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

16. (a) Informant Hospital Records

(b) Address Nevada mo.

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof Feb. 26 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Place: burial or cremation Hosp. Cemetery

(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 Edward [unclear]

(b) Address Nevada mo.

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

19. (a) 2-26-45 (b) Hoyl B. Beurek  
(Date received local registrar) (Registrar's signature)

23. Signature R. B. Fisher (M. D. or \_\_\_\_\_)  
Address Nevada mo. Date signed 2-28-45

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

RECEIVED

DATE

2-45-146

2-7-45

**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 *not*.....  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed *Allen J. Hoyle*.....  
Licensed Embalmer No. *1968*.....  
P. O. Address *Nevada 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.**