

FILED APR 17 1945

Registration District No. 42

Primary Registration District No. 000

Registrar's No. 390

1. PLACE OF DEATH:

(a) County W. Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution here
In this community 15 years 2 mos 9 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Miss Sarah I. Mallett

3. (b) If veteran, name war No

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive, years _____
(Month) (Day) (Year)

7. Birth date of deceased Jan 9 1872
(Month) (Day) (Year)

8. AGE: Years 73 Months 6 Days 29
If less than one day hr. _____ min. _____

9. Birthplace Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Dressmaker

11. Industry or business _____

12. Name Sydney B. Mallett

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

14. Maiden name Mary McEwen

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

16. (a) Informant State Hospital non record

(b) Address St. Joseph Mo

17. (a) Burial (b) Date thereof 4/16/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cem.

18. (a) Signature of funeral director Samuel Lawrence

(b) Address 3024 Zippert Blvd. Mo.

19. (a) 4-9-45 (b) Selen J. Chalko
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4/8 day _____
year 1945 hour 11 minute a M.

21. I hereby certify that I attended the deceased from Jan 1st 1945 to 4/8 1945
that I last saw her alive on 4/7 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage of the brain
Due to Cerebral arteriosclerosis

Duration 4 days

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy 830

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) _____
- (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 D. E. Collins (M.D. or other) _____
Address State Hospital #2 St. Joseph Date signed 4/8/1945

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

1377

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.....

J. L. Davidson
.....
Licensed Embalmer No. *7168*
.....
P. O. Address.....

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.