

FILED AUG 10 1945

State File No. _____

Registration District No. 260

Primary Registration District No. 6225

Registrar's No. 113

1. PLACE OF DEATH:

(a) County Nevada

(b) City or town Nevada Washington

(c) Name of hospital or institution State Hospital No 3

(d) Length of stay: In hospital or institution 42 years 4 mo 10 d

In this community 42 years 4 mo 10 d

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Warrenton

(d) Street No. unknown

(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME CORA-MILLS

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27 year 1945 hour 1 minute 15 A.M.

4. Sex female 5. Color or race wh.

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

6. (b) Name of husband or wife unknown

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

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

21. I hereby certify that I attended the deceased from Oct 1939 to July 27 1945 that I last saw her alive on July 26 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia RT plus Emphysema RT

8. AGE: Years 66 Months unknown Days unknown If less than one day min.

Due to Diabetes mellitus

Due to W

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

10. Usual occupation none

Other conditions Dementia Precox (Include pregnancy within 3 months of death)

Major findings: Of operations no operations

11. Industry or business none

12. Name unknown

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

14. Maiden name unknown

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

Of autopsy no autopsy

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

16. (a) Informant Records State Hosp

(b) Address Nevada no

17. (a) Burial (b) Date thereof 7-28-45

(c) Place: burial or cremation Hospital Cemetery

18. (a) Signature of funeral director Hazel B. Beurch

(b) Address Nevada no

19. (a) 7-27-45 (b) Hazel B. Beurch

(a) Accident, suicide, or homicide (specify) No

(b) Date of occurrence _____

(c) Where did injury occur? _____

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

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Paul L. Barone (M. D. or other) July 27

Address State Hosp No 3 Date signed July 27

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

MOTHER FATHER

RECEIVED

District Health Officer No. 7

District File Number

7-455-269
8-9-43

4700

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.....

working under my personal supervision.

Registered Apprentice No.

Signed *[Signature]*

Licensed Embalmer No. 1760

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.