

Registration District No. **38**

Primary Registration District No. **3006**

Registrar's No. **226**

1. PLACE OF DEATH:

(a) County **Bacon et. Columbia**
(b) City or town **Columbia**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Ellis Krochil State Cancer Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **about 12 hrs**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **Shannon** **101**
(c) City or town **Round Springs**
(If outside city or town limits, write "RURAL")
(d) Street No. **0**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

JANIE LIZZIE PIATT

3. (b) If veteran, _____ name war _____
3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Divorced**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **11 1895**
(Month) (Day) (Year)

8. AGE: Years **50** Months **9** Days **30** If less than one day
hr. _____ min. _____

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER
12. Name **D K**
13. Birthplace **D K** **9**
(City, town, or county) (State or foreign country)
14. Maiden name **D K**
15. Birthplace **D K** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Hospital Record**

(b) Address **Columbia Mo**

17. (a) **Burial** (b) Date thereof **Aug 30 45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Round Springs Mo**

18. (a) Signature of funeral director **R. Overstreet**

(b) Address **Columbia Mo**

19. (a) **Aug 30 1945** (b) **Mrs. R. E. Palmer**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **29**
year **1945** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **8/29/45** to **8/29/45**
that I last saw her alive on **Death 11:59 AM**
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerotic nephrosclerosis**
Due to **?**
Duration **Years**

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

Major findings: **13/10**
Of operations _____
Of autopsy **See above**
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?

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

23. Signature **Lawrence R. Berkman** (M. D. or other) **M.D.**
Address **Cancer Hospital Columbia Mo** Date signed **8/29/45**

1925

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

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.....

[Handwritten Signature]
Licensed Embalmer No. 3183
P. O. Address Columbia 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.