. S. No. 2
0M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36652

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1267

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Saint Joseph, (If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 9 days 0 (Specify whether

In this community 9 days, years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Doniphan 999

(c) City or town Highland, 14 (If outside city or town limits, write "RURAL")

(d) Street No. 5 (If rural, give location)

(e) Citizen of foreign country? no 2 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Grace Mauden Hixson

3. (b) If veteran, name war none

3. (c) Social Security No. unknown

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Jesse Hixson

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

7. Birth date of deceased January (Month) 28 (Day) 1891 (Year)

8. AGE: Years 54 Months 9 Days 29 If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business

FATHER
12. Name Richard F. Overman
13. Birthplace Villisca (City, town, or county) Iowa (State or foreign country)

MOTHER
14. Maiden name Mary F. Corbet
15. Birthplace Severancy (City, town, or county) Kansas (State or foreign country)

16. (a) Informant Hospital Records

(b) Address St. Joseph, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/27/45 (Month) (Day) (Year)

(c) Place: burial or cremation Highland, Kansas,

18. (a) Signature of funeral director Heaton Brooks & Bowman

(b) Address 319 So. 10th, Street,

19. (a) Dec 3 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

1428

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 27th year 1945 hour 10:00 minute 03 a.M.

21. I hereby certify that I attended the deceased from 11-17-45, 19 to 11-27-, 1945 that I last saw her alive on 11-27-, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis - Chronic - Aggravated by Gastric resection

Due to Bleeding gastric ulcer

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Kissing gastric ulcers

Of autopsy none.

Duration

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 Paul Forgrave (M.D. or other)

Address St Joseph Mo Date signed 11-27-45

(Licensed Embalmer's Statement on Reverse Side)

731 Sanson
2-3355

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 Frank A. Bowman

Licensed Embalmer No. 1710

P. O. Address St Joseph 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.