

S. No. 2
M-5-43
5-17-39
I X36871

State File No.

FILED JAN 11 1946

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 190

1. PLACE OF DEATH:

(a) County Vernon

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

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

(d) Length of stay: In hospital or institution 9 yr. 7 mo. 26 da
(Specify whether years, months or days) Same time

In this community.....

3. (a) PRINT FULL NAME August Deviney

3. (b) If veteran, name war ?

3. (c) Social Security No.

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced ? 9

6. (b) Name of husband or wife ?

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

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

8. AGE:

Years	Months	Days	If less than one day
<u>?</u>			hr. min.

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

10. Usual occupation ?

11. Industry or business ?

MOTHER FATHER

12. Name Unknown

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

14. Maiden name ?

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

16. (a) Informant Hospital Records, Nevada Mo.

(b) Address ?

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

(c) Place: burial or cremation Buried Osceola

18. (a) Signature of funeral director Osceola Fun. Home

(b) Address Osceola Mo.

19. (a) 12-26-45 (Date received local registrar) (b) Walter J. Nancy (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair

(c) City or town Osceola (?)
(If outside city or town limits, write "RURAL")

(d) Street No. County Supervisory
(If rural, give location)

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24
year 1945 hour 7:30 minute P. M.

21. I hereby certify that I attended the deceased from 6-4-45
....., 19....., to 12-24-45 19.....
that I last saw him alive on 12-24-1945 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Duration

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy ?

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 R.B. Dister (M. D. or other)
Address Nevada Mo. Date signed 12-24-45

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

Catherine Yancey
Newbold Years Office

REC-1173

12-43-7311
1-10-46

DATE TIME

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

Paul J. Stone

Licensed Embalmer No. 3990

P. O. Address *Osceola 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.

MISSOURI DEPARTMENT OF HEALTH - DIVISION OF PUBLIC HEALTH