

No. 2  
-12-45  
5-17-39  
I X47070

FILED OCT 3 1946

State File No. \_\_\_\_\_

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 115

1. PLACE OF DEATH:

(a) County Denver  
(b) City or town Forest Washington  
(c) Name of hospital or institution: State Hospital #32  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 to 6 days  
6 months 6 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Kennett City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1540 VE 50th  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MABEL WEST

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12  
year 1946 hour 3 minute 20 P.M.  
21. I hereby certify that I attended the deceased from 3-20 to 9-12-1946  
that I last saw him alive on 9-12-1946  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color of hair White (a) Single, Married  
6. (b) Name of husband or wife M. West (c) Age of husband or wife if alive 48 years  
7. Birth date of deceased: Aug 17 1905  
(Month) (Day) (Year)

Immediate cause of death Subacute Meningo-encephalitis

8. AGE: Years 41 Months 9 Days 23 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business None

12. Name Wattie T. Roark

13. Birthplace Miller Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Georgia Ann Roark

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

16. (a) Informant Hospital record

(b) Address Nevada Mo

17. (a) Removal (b) Date thereof 9-13-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nevada City, Mo.

18. (a) Signature of funeral director DW Newberry

(b) Address 1401 Bush Creek KCMo

19. (a) 9-14-46 (b) Pathway Janczy  
(Date received local registrar) (Registrar's signature)

Other conditions ✓  
(Include pregnancy within 6 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 30 Pa

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(c) 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 R. H. Hall (M. D. or other) \_\_\_\_\_  
Address Nevada Mo Date signed 9-12-46

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

MOTHER FATHER

RECEIVED

Div. Officer No. 7,

9-46-946

10-2-46

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

*Emile M. Carlson*

Licensed Embalmer No.

3605

P. O. Address

K C 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.