

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 17 1946
59

Registration District No. _____

Primary Registration District No. 5223

Registrar's No. 177

1. PLACE OF DEATH:

(a) County Cass

(b) City or town Archie Rural Everitt Township
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 16 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass ¹⁹

(c) City or town Archie Rural Everitt Township
(If outside city or town limits, write "RURAL")

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

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

If yes, name country _____

3. (a) PRINT FULL NAME Verdie Abbie Hess

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex female 5. Color or race W.

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

6. (b) Name of husband or wife deceased

6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased Oct. 3-9 1867
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>2</u>	<u>6</u>	hr. _____ min. _____

9. Birthplace Monroe Wis. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business

MOTHER FATHER

12. Name John Henry Warren

13. Birthplace Ohio 1
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Jane Sayard

15. Birthplace Maine 1
(City, town or county) (State or foreign country)

16. (a) Informant Joseph Hess

(b) Address Archie Mo

17. (a) Burial (b) Date thereof 12-12-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mercedes Separ

18. (a) Signature of funeral director Atkinson Bros.

(b) Address Archie Mo.

19. (a) 12-10-1946 (b) Laura J. Jones.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 9th
year 1946 hour 11 minute _____ P. M.

21. I hereby certify that I attended the deceased from 12-1
1946 to 12-9 1946
that I last saw her alive on 12-8 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomatous abdomen generally ^{Duration} 1 month

Due to Carcinoma, uterus 1 year

Due to _____

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

Major findings: _____

Of operations: _____

Of autopsy: _____

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 O. J. Barger M.D. (M. D. or other) B

Address Harrisonville, Mo. Date signed 12-10-46

PHYSICIAN

Underline the cause to which death should be charged statistically.

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~~ me

....., Registered Apprentice No.
working under my personal supervision.

Signed. Hoyd Harrison
Licensed Embalmer No. 3920
P. O. Address Harrisonville

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.