

No. 2
12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED DEC 12 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43322

State File No. _____

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 153

1. PLACE OF DEATH:

(a) County Vernon

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

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

(d) Length of stay: In hospital or institution 8 mo. 12 da
Same time (Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede 108

(c) City or town Lebanon
(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 Isaac Whitson

3. (b) If veteran, name war 2

3. (c) Social Security No. 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day first
year 1946 hour 55 minute PM M.

21. I hereby certify that I attended the deceased from 3-18-46
to 12-1-1946, 19____ to 12-1-1946, 19____
that I last saw him alive on Dec. 1-1946, 19____
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Sarah Rooney

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

7. Birth date of deceased Feb. 25 - 1855
(Month) (Day) (Year)

Immediate cause of death Broncho Pneumonia Duration 3 da.

8. AGE:	Years	Months	Days	If less than one day
	<u>91</u>	<u>10</u>	<u>6</u>	hr. _____ min. _____

Due to _____

Due to Generalized Arteriosclerosis

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

MOTHER FATHER

11. Industry or business _____

12. Name Jim Whitson

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

14. Maiden name Mauida Boyles

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

Major findings: _____

Of operations _____

Of autopsy 107

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Hospital Records

(b) Address Nevada Mo

17. (a) Burial (b) Date thereof Dec 3 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cemetery

18. (a) Signature of funeral director Ray Funeral Director

(b) Address Nevada Mo

19. (a) 12-3-46 (b) Walsh H. Hawley
(Date received local registrar) (Registrar's signature)

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 Y

23. Signature R. B. Dester (M. D. or other) _____

Address Nevada Mo Date signed 12-1-46

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

Date Filed 12-11-46
DISTRICT 11-46-3093
RECEIVED

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Allen S. Kaye
Licensed Embalmer No. 1968
P. O. Address Nevada, 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.