

FILED APR 18 1947
Registration District No. **360**

Primary Registration District No. **6225**

Registrar's No. **28**

1. PLACE OF DEATH:
 (a) County. Vernon
 (b) City or town. Washington Tennesseey - rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: State Hospital #3. 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20 yrs. 5 mos. 8 days
Specify whether
 In this community 20 years 5 mos. 8 days
years, months or days

3. (a) PRINT FULL NAME. AMELIA - PINE.
3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex F / **5. Color or** W **6. (a) Single, widowed, married,** single
race
6. (b) Name of husband or wife. - **6. (c) Age of husband or wife if** -
alive years

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

8. AGE: Years 60 Months ? Days ? If less than one day
 hr. 0 min.

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

10. Usual occupation none

11. Industry or business none

12. Name Andy Pine
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Anna Kellogg
15. Birthplace Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant William Pine
(b) Address Centerview Mo.

17. (a) Pension **(b) Date thereof** 4-10-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Centerview Cemetery

18. (a) Signature of funeral director J. B. East
(b) Address Holden Mo.

19. (a) 4-11-47 **(b) Nathurn Yancey**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri **(b) County** Johnson
 (c) City or town Centerview
(If outside city or town limits, write "RURAL")
 (d) Street No. Rural.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 4 day 10
 year 1947 hour 6:35 minute P. M.

21. I hereby certify that I attended the deceased from 4-7- 1947 to 4-10- 1947
 that I last saw her alive on 4-10- 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral Hemorrhage **Duration** 4 days

Due to _____
Imbecility **Duration** Imbecility

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

Major findings: (3)
 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) (a) Means of injury 11

23. Signature J. B. East **(M. D. or other)** _____
Address State Hospital #3 **Date signed** 4-10-47

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

38
00
Washington to St.

RECEIVED
District Health Officer No. 7,
District file number 3-47-475-
Date filed 4-17-47

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 _____

Licensed Embalmer No. 4059

P. O. Address Holden Mass

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, above space should be left blank.