

Registration District No. **360** Primary Registration District No. **6225**

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

1. PLACE OF DEATH:
(a) County **Vernon**
(b) City or town **Grand Washington**
(c) Name of hospital or institution: **State Hospital # 2**
(d) Length of stay: In hospital or institution **mo 2 1 day**
In this community **18 months 21 days**

3. (a) PRINT FULL NAME **ALICE JANE WHITE**
8. (b) If veteran, name war 8. (c) Social Security No.
4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Wid**
6. (b) Name of husband or wife **W** 6. (c) Age of husband or wife if alive **47** years
7. Birth date of deceased **12-19-1868**

8. AGE: Years **78** Months **3** Days **21** If less than one day hr. min.

9. Birthplace **Cleveland Mo** (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business
12. Name **Hanson, Roy**
13. Birthplace **Tenn**
14. Maiden name **Martha Sherman**
15. Birthplace **Tenn**

16. (a) Informant **Hospital record**
(b) Address

17. (a) **BURIAL** (b) Date thereof **April 12-1947**
(c) Place: burial or cremation **AURORA MISSOURI**

18. (a) Signature of funeral director **J.W. Maple**
(b) Address **Chever, Missouri**

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

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Lawrence**
(c) City or town **Aurora**
(d) Street No. **108**
(e) If foreign born, how long in U. S. A. **no** years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **10**
year **1947** hour **12** minute **45** P.M.

21. I hereby certify that I attended the deceased from **2-19-1947** 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 **Influenza**

Due to

Due to

Other condition **Arteriosclerosis**
(Include pregnancy within 3 months of death)

Major findings: Of operations **no**

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) (a) Means of injury **no**
23. Signature **R.S. Hall** (M.D. or other) **MD**
Address **Newada Mo** Date signed **4-10-47**

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

RECEIVED
District Health Officer No. 7,
3-47-476
District No. 7,
4-17-47
Date Filed

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 Y W Moyles
Licensed Embalmer No. 2985
P. O. Address Clemmo

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.