

S. No. 2
-12-45
5-17-39
1 X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17999

FILED JUN 6 1947

Registration District No. 288

Primary Registration District No. 5655

Registrar's No. 83

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

1. PLACE OF DEATH:
 (a) County Lawrence
 (b) City or town Mt. Vernon, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Mo. State Sanatorium
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 years 15 days
(Specify whether years, months or days)
 In this community 2 years 15 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Lafayette
 (c) City or town Lexington
(If outside city or town limits, write "RURAL")
 (d) Street No. none
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Catherine Ewing
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Black
 6. (a) Single, widowed, married, divorced, Separated
 6. (b) Name of husband or wife not known
 6. (c) Age of husband or wife if alive unknown years
 7. Birth date of deceased Aug 10 1906
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>9</u>	<u>1</u>	_____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER
 12. Name Robert Jackson
 13. Birthplace Lexington Missouri
(City, town, or county) (State or foreign country)
 14. Maiden name Martha Jackson
 15. Birthplace Lexington Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Ethel McMichael, Record Clerk
 (b) Address Mt. Vernon, Mo.

17. (a) Removal (b) Date thereof 5-12-47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Lexington Mo

18. (a) Signature of funeral director [Signature]
 (b) Address Leavenworth

19. (a) 5/24-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 11th year 1947 hour 12:00 noon minute _____ M.
 21. I hereby certify that I attended the deceased from 4-26-45 to May 11 1947
 that I last saw her alive on May 11 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Massive Pulmonary hemorrhage
few minutes duration
 Due to Pulmonary tuberculosis over 7 years

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

Major findings:
 Of operations 13B
 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 _____

23. Signature Y. F. Luptakawa M.D.
 Address _____ Date signed 5-11-47

RECEIVED
District Health Officer No. 6,
District File Number 647-589
Date Filed JUN 4 1947

JUN 6 1947

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 Geo. N. Green
Licensed Embalmer No. 4220
P. O. Address Lexington, 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.