

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 122

1. PLACE OF DEATH:

(a) County: Vernon
(b) City or town: Washington Twp - 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 3 yrs. 2 mos. 23 days
(Specify whether
In this community 3 yrs - 2 mos - 23 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson
(c) City or town: Independence
(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.

3. (a) PRINT FULL NAME

MOLETTE
Mollie Morhead.

8. (b) If veteran, name war no

3. (c) Social Security No. OK

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife OK

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

7. Birth date of deceased: 8- (Month) 9- (Day) 1869 (Year)

8. AGE: Years 79

Months 0

Days 20

If less than one day
hr. min.

9. Birthplace: Randolph County Mo (City, town, or county) U (State or foreign country)

10. Usual occupation: House wife

11. Industry or business

12. Name: OK

13. Birthplace: OK

14. Maiden name: OK

15. Birthplace: OK

16. (a) Informant: Records

(b) Address: State Hospital # 3.

17. (a) Removal (b) Date thereof: 8-30-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director: Allen J. Hays

(b) Address: W Nevada Mo

19. (a) 8-30-48 (b) Ruthie Hays
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 29
year 1948 hour 9:40 minute P. M.

21. I hereby certify that I attended the deceased from 6-1- 1946, to 8-29- 1948.
that I last saw her alive on 8-29- 1948
and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchitis Pneumonia
Heart

Due to: Traumatic fracture Rt. Radius 7-3-1948

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: July 3, 1948
(c) Where did injury occur? State Hospital # 3 - Vernon Co Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
State Hospital # 3.

While at work? no (Specify type of place)
(g) Means of injury: Fred from Red.

23. Signature: R. Bunch (M. D. or other)
Address: State Hospital # 3 Date signed 8-29-48

Duration
1 day

PHYSICIAN
Underlines the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 7,

District File Number 8-48-1016

Date Filed 9-8⁷-48

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.....

Best B. Bennett, Registered Apprentice No. 83
working under my personal supervision.

Signed Allen V. Hayes

Licensed Embalmer No. 1968

P. O. Address Nevada, 7

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.