

Registration District No. 203

Primary Registration District No. 5655

Registrar's No. 121

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Mt. Vernon  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri State Sanatorium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days)

3: (a) PRINT FULL NAME Jessie Mae Bias

3: (b) If veteran, name war no 3: (c) Social Security No. none

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 4 1933  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>14</u>	<u>10</u>	<u>1</u>	hr. _____ min.

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

10. Usual occupation School child

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Resan Bias

13. Birthplace St. Mary's Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Vera Lollice

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

16. (a) Informant E. McMichael, Record Clk.

(b) Address Mo. State San., Mt. Vernon, Mo.

17. (a) Removal (b) Date thereof Oct. 5 - 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crystal City, Mo.

18. (a) Signature of funeral director: Max J. Smith

(b) Address Lawrence, Mo.

19. (a) 10-6-48 (b) Caril Hendricks  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson  
(c) City or town Crystal City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 219 Country Road  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 5th  
year 1948 hour 5:00 minute \_\_\_\_\_ A.M.

21. I hereby certify that I attended the deceased from Oct. 2  
1948, to Oct. 5, 1948  
that I last saw her alive on Oct. 5, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Pulmonary Tuberculosis Unknown

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 1 2 B  
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? \_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. F. Hayward (M. D. or other) MD.  
Address Mt. Vernon, Missouri Date signed 10-5-48

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

RECEIVED

District Health Officer No. 6

District File Number 1048-1148

Date Filed 10-9-48

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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*Max S. Fossitt*

Licensed Embalmer No. 4252

P. O. Address *McKenno, 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.