

FILED JUN 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22343

BIRTH NO. _____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6225 Registrar's No. 707

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper 41</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Washington Twp</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Joplin</u>	
c. LENGTH OF STAY (in this place) <u>4 years</u>		d. STREET ADDRESS (If rural, give location) <u>1012 West Third</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #3</u>		e. (Last) <u>Paragge</u>	
3. NAME OF DECEASED (First) <u>Pansy</u> (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year) <u>June 13 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>March 10, 1896</u>	
9. AGE (in years last birthday) <u>53</u>		10. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Babb</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Ironheart</u>	
14. NAME OF HUSBAND OR WIFE <u>Sol Brogg</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY (unknown) NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Records State Hospital #3 Nevada Mo</u> ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Multiple Bilateral Abscesses of lungs</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Etiology unknown.</u> DUE TO (c) <u>Involuntarial Melancholia</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from <u>Sept 27, 1948</u> , to <u>June 13, 1949</u> , that I last saw the deceased alive on <u>June 13, 1949</u> , and that death occurred at <u>11:10 P.M.</u> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>Paul L. Barone M.D.</u>		23b. ADDRESS <u>State Hosp #3 Nevada Mo</u>	
23c. DATE SIGNED <u>June 13 1949</u>		24a. BURIAL, CREMATION, OR REMOVAL (Specify) _____	
24b. DATE <u>June 14-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>State Hosp #3</u>	
24d. LOCATION (City, town, or county) <u>Nevada Mo</u>		25. GENERAL DIRECTOR'S SIGNATURE <u>Ferry</u> ADDRESS <u>Nevada 200</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>June 14, 1949</u>		3211 _____	

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

108
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RECEIVED

District Health Officer No. **71**

District File Number **5-49-740**

Date Filed **6-20-49**

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 _____

Francis J. Lewis

Student Embalmer No. **330**

working under my personal supervision.

Signed *Francis J. Lewis*
Student Embalmer

Signed _____

[Signature]

Licensed Embalmer No. **1760**

P. O. Address **Merida 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.