

FILED AUG 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22609

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>846</u>			
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Grundy</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>6 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Trenton</u>		1			
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>State Hospital # 2</u>				d. STREET ADDRESS (If rural, give location) <u>1316 1/2 Main St.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lulu</u> b. (Middle) <u>M.</u> c. (Last) <u>Hiatt</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 28, 1949</u>			1			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>Unknown</u>			
9. AGE (In years last birthday) <u>41</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>			11. BIRTHPLACE (State or foreign country) <u>Trenton, Missouri</u>			
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Deweyn Hiatt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>nil</u>			17. INFORMANT'S SIGNATURE OR NAME <u>Records State Hosp. St. Joseph, Mo.</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Atrophic decompensated heart</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Chronic alcoholism</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs 7</u> <u>434 3</u> <u>69 1/4</u>	
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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>Nov 15</u> , 19 <u>49</u> , to <u>7-28</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>7-28</u> , 19 <u>49</u> , and that death occurred at <u>5:15 P. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>O. B. Gossins M.D.</u>				23b. ADDRESS <u>State Hospital # 2 St. Joseph</u>		23c. DATE SIGNED <u>7-28-1949</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>7-31-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Horton, Kansas</u>		24d. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG. <u>Aug. 5, 1949</u>		REGISTRAR'S SIGNATURE <u>O. B. Jenkins</u>		392		25. FUNERAL DIRECTOR'S SIGNATURE <u>Stame, Funeral Home - St. Joseph, Mo.</u>			
ADDRESS									

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No.

working under my personal supervision.

Signed Charles M. Hanna

Signed
Student Embalmer

Licensed Embalmer No. 4487

P. O. Address St. Joseph

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

If this body is not embalmed, fact should be so stated above.