

FILED MAR 13 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 3919

|   |                           |   |  |   |   |  |   |
|---|---------------------------|---|--|---|---|--|---|
| BIRTH NO. _____   |                           | REG. DIST. NO. 42   |  | PRIMARY REG. DIST. NO. 1000   |   | Registrar's No. 261  |   |
| 1. PLACE OF DEATH<br>a. COUNTY Buchanan   |                           |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri b. COUNTY Jackson |   |  |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN St. Joseph  |                           | c. LENGTH OF STAY (in this place)<br>9 yrs - 7 mo 12 da   |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN Kansas City                                   |   | 3228   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital no 2   |                           |   |  | d. STREET ADDRESS (If rural, give location)<br>1416 Hardisty 1  |   |  |   |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) Bessie  |                           |   | b. (Middle) -                            |   | c. (Last) HEARN                         |  | 4. DATE OF DEATH (Month) (Day) (Year)<br>March 3 - 1950 |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>never married   |  | 8. DATE OF BIRTH<br>July 7 1895   | 9. AGE (In years last birthday)<br>54 - | 10. MONTHS<br>7  | 11. DAYS<br>26  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Tyrist   |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br>Ontario Canada   |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                   |   |
| 13a. FATHER'S NAME<br>H. H. Hearn   |                           |   | 13b. MOTHER'S MAIDEN NAME<br>Low Hillary |   |   | 14. NAME OF HUSBAND OR WIFE  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>no  |                           | 16. SOCIAL SECURITY NO.<br>none   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br>Alfred Mueller 1416 Hardisty K.G.  |   |  |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis<br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last.<br>DUE TO (b) Hypertension + arterio-sclerosis<br><br>DUE TO (c)<br><br>11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |   |   |  |   |
| 19a. DATE OF OPERATION  |                           | 19b. MAJOR FINDINGS OF OPERATION  |  |   |   | 20. AUTOPSY?<br>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) (Min.)  |                           | 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 Feb 1, 1950, to March 3, 1950, that I last saw the deceased alive on March 2, 1950, and that death occurred at 1:25 P.M., from the causes and on the date stated above.  |                           |   |  |   |   |  |   |
| 23a. SIGNATURE (Degree or title)<br>Forrest Thorne M.D.   |                           |   |  | 23b. ADDRESS<br>St. Joseph Mo 90 State Hosp No 2  |   | 23c. DATE SIGNED<br>3/5 50   |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)   |                           | 24b. DATE<br>Mar 3, 1950  |  | 24c. NAME OF CEMETERY OR CREMATORY  |   | 24d. LOCATION (City, town, or county) (State)<br>Kansas City, Mo.        |   |
| DATE REC'D BY LOCAL REG.<br>Mar 4, 1950   |                           | REGISTRAR'S SIGNATURE<br>G. B. Jenkins 382  |  | FEDERAL DIRECTOR'S SIGNATURE<br>D. W. Haunover  |   | ADDRESS<br>Kansas City, Mo.  |   |

(Licensed Embalmer's Statement on Reverse Side)

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

1117  
2

*Not Embalmed*

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**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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. \_\_\_\_\_

Signed \_\_\_\_\_  
Student Embalmer

Signed *Wayne L. Daniel*

Licensed Embalmer No. *4902*

P. O. Address *KCMO.*

**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.**