AUG 10 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24610

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 728

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

1. PLACE OF DEATH:
(a) County BUCHANAN 3
(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STATE HOSPITAL No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 mo. 27 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1724 Penn
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 22 years.

3. (a) PRINT FULL NAME Jeanette M. Harwell 640
3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE
4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Common law
6. (b) Name of husband or wife C. S. Harwell (Common law 6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased October (Month) 29 (Day) 1899 (Year)

8. AGE: Years 40 Months 8 Days 8 If less than one day ..... hr. ..... min.

9. Birthplace Brest (City, town, or county) France (State or foreign country)
10. Usual occupation Pantry women in Hotels 7
11. Industry or business
FATHER
12. Name Unknown 7
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Records State Hosp #2
(b) Address St. Joseph, Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-8-40 (Month) (Day) (Year)
(c) Place: burial or cremation Kansas City Mo
18. (a) Signature of funeral director Pleeman & Son
(b) Address St Joseph, Mo
19. (a) July 8 1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7 year 1940 hour 5 20 minute a M.
21. I hereby certify that I attended the deceased from January 10 1940 to July 7 1940 that I last saw her alive on July 6 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Psychosis with Syphilis of Central Nervous System — Duration 1939
Due to Meningo-Encephalitic type
Due to
Other conditions (Include pregnancy within 3 months of death) 34
Major findings:
Of operations no operation
Of autopsy none done

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) no
(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)
While at work? — (e) Means of injury —
23. Signature D. P. Johnson (M. D. or other) M. D.
Address State Hosp #2, St. Joseph Date signed 7-7-40

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 3634

P. O. Address 20W Linwood

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.