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AUG 28 1940  
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5-17-39  
P 1 X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **26542**  
Registrar's No. **186**

Registration District No. **875** Primary Registration District No. **6162**

08  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Vernon Wash Terr  
(b) City or town Nevada  
(c) Name of hospital or institution: State Hospital No 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 yrs 9 18 days  
In this community 500 years, months or days (Specify whether)

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

3. (a) PRINT FULL NAME Elizabeth (Betty) Denny  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. Not known

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 31st year 1940 hour 5 minute 30 P.M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from Aug 24th, 1939, to July 31st, 1940 that I last saw her alive on July 31st, 1940 and that death occurred on the date and hour stated above.  
Immediate cause of death Pulmonary Tuberculosis Duration \_\_\_\_\_

7. Birth date of deceased Oct 2nd 1857  
(Month) (Day) (Year)

Due to \_\_\_\_\_  
Due to 77

8. AGE: Years 82 Months 9 Days 29 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Other conditions Senility  
(Include pregnancy within 3 months of death)

9. Birthplace Seymour Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation House work

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name Larwood Denny  
13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Eliza Jones  
15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant State Hosp. No 3 Records  
(b) Address Nevada, Mo

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? 795  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

17. (a) Burial (b) Date thereof 8/2/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation State Hosp. Cem.

18. (a) Signature of funeral director Martha Beechinger  
(b) Address Nevada, Mo

23. Signature G.S. Warwick (M. D. or other) \_\_\_\_\_  
Address State Hospital No 3 Date signed 7/31/40  
Nevada, Mo

19. (a) 8/1/1940 (b) Abner V. Denny  
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 7,

District File Number

8-40-1145

Date Filed

8-9-40

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

*Mark Eichinger*

Licensed Embalmer No.

12636

P. O. Address

*Nevada 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, above space should be left blank.