

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18436

FILED JUN 7 1945

State File No.

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 83

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

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Russell - Washington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution State Hosp. # 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Months, 3 days
(Specify whether years, months or days)

In this community Same
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Barren 108

(c) City or town Pleasant Hill
(If outside city or town limits, write "RURAL")

(d) Street No. 302 Locust St.
(If rural, give location)

(e) Citizen of foreign country? () (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Kathleen L. Dwyer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced ()

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased. (Month) (Day) (Year)

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

75 8 15 hr. min.

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

10. Usual occupation None

11. Industry or business

MOTHER FATHER

12. Name Daniel Dwyer

13. Birthplace Ireland 11
(City, town, or county) (State or foreign country)

14. Maiden name Mary Kane

15. Birthplace Ireland 11
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Nevada, Mo.

17. (a) Burial (b) Date thereof 5-28-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Hill

18. (a) Signature of funeral director Walter Herich

(b) Address Pleasant Hill, Mo

19. (a) 5-26-45 (b) Hazel B. Burch
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26th year 1945 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from Feb. 1st 1945 to May 26th 1945

that I last saw her alive on May 28th 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Epithelioma
frontal region of face

Duration 5 months

Due to

Due to

Other conditions Senile Dementia
(Include pregnancy within 3 months of death)

Major findings: Of operations 53

Of autopsy

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)

(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?

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

23. Signature W. R. Summers (M. D. or other)

Address Nevada, Mo. Date signed 5-26-45

1531

RECEIVED

District Health Officer No. 7,

District No. 5-45-484

Date Filed 6-6-45

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. 3599

P. O. Address Pleasant Hill 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.