

No. 2
12-45
17-39
X47070

FILED JUN 28 1946

Registration District No. 360

Primary Registration District No. 6225

1. PLACE OF DEATH:

(a) County Union

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

(c) Name of hospital or institution State Hospital #32
(If not in hospital or institution, write street number or location)

(d) Length of stay: 1 mo 24 dy
7 mo 24 days (Specify whether years, months or days)

In this community 7 mo 24 days

3. (a) PRINT FULL NAME ROSE DAY

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 5. Color or race Wh

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 3 years

7. Birth date of deceased 3 - 3 - 1888
(Month) (Day) (Year)

8. AGE: Years 58 Months 3 Days 14 hr. min.

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

10. Usual occupation none

11. Industry or business

MOTHER FATHER

12. Name unknown 9

13. Birthplace unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name unknown 9

15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital record

(b) Address Nevada Mo

17. (a) Burial (b) Date thereof 6-19-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cem

18. (a) Signature of funeral director J. H. ...

(b) Address Nevada Mo

19. (a) 6-19-46 (b) Kathryn James
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. Courtesy Homes
(If rural, give location)

(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Bohemia

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17 year 1946 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from 11-16-46 to 6-17-46
that I last saw her alive on June 16 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Heart Disease Duration

Due to

Due to

Other conditions Sementia Praxia Peruvia
(Include pregnancy within 3 months of death)

Major findings: none 30%
Of operations

Of autopsy yes - findings as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature M. R. ... (b) 6-17-46
Address Nevada Date signed

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

RECEIVED

District Health Officer No. 7,

District File No. 5-46-633

Date Filed 6-26-46

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed L. B. Terry

Licensed Embalmer No. 1760

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, fact should be so stated above.