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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 23 1947
Registration District No. 283

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 59

Primary Registration District No. 5655

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

1. PLACE OF DEATH:
(a) County Lawrence
(b) City or town Mount Vernon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 130 days
In this community 130 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Josephine Washington
3. (b) If veteran, name war no 3. (c) Social Security No. 491-22-5056

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Harry Washington 6. (c) Age of husband or wife if alive 23 years
7. Birth date of deceased July 16 1926
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
20 8 23 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Owen Ginn
13. Birthplace Unknown Missouri
(State or foreign country)
14. Maiden name Mable Ginn
15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Ethel McMichael, Record Clerk
(b) Address Mo. State San, Mount Vernon, Mo.

17. (a) Removal (b) Date thereof 4-8-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St Joseph Mo

18. (a) Signature of funeral director [Signature]
(b) Address St Joseph Mo
19. (a) 4847 (b) CR Philbrick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanana
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1401 Seymour
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8
year 1947 hour 1 minute 25 P.M.
21. I hereby certify that I attended the deceased from November 30, 1946, to April 8, 1947,
that I last saw her alive on April 8, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis empyema & Broncho-pneumonia fistula Duration about 3 mo.
Due to Pulmonary Tuberculosis over 9 mo.
Due to _____
Other conditions 13B
(Include pregnancy within 3 months of death)

Major findings: Bilat. ulcers of caecum
Of caecum: pulm. tbc. The empyema & bronchopneumonia
Of autopsy: bronchopneumonia fistula
over, the typhlitis
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) Means of injury 0
23. Signature G. F. Kuykawa (M.D. or other) M.D.
Address Mo. State San, Mount Vernon Date signed 4-8-47

RECEIVED

District Health Officer No. 6,

District File Number 447-484

Date Filed APR 22 1947

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.....

Geo. B. Orr

Licensed Embalmer.....

P. O. Address.....

*946
Mr. Tomson*

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.

Registration District No. 383

Primary Registration District No. 5655-

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Josephine Washington
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased July 16 (Month) (Day) (Year)

8. AGE: Years 20 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 4-8-47 (b) ER Philbrick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

14043