

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 378

1. PLACE OF DEATH

(a) County Callaway  
(b) City or town Callaway  
(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 14 yrs 3 m 1 day  
(Specify weeks)  
In this community same  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME AGNES ELIZABETH CATHOART  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct day 24  
year 1947 hour 11 minute 15 M.  
21. I hereby certify that I attended the deceased from Oct 20  
1947 to Oct 24, 1947  
that I last saw her alive on Oct 24  
and that death occurred on the date and hour stated above.

4. Sex f 5. Color or race white 6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased DL  
(Month) (Day) (Year)

Immediate cause of death Chronic Myo Carditis  
Duration \_\_\_\_\_

8. AGE: Years 77 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: AMD  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Canada  
(City, town, or county) (State or foreign country)  
10. Usual occupation none

11. Industry or business \_\_\_\_\_  
12. Name DL  
13. Birthplace DL  
(City, town, or county) (State or foreign country)  
14. Maiden name DL  
15. Birthplace DL  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Records State Hospital  
(b) Address Hullon mo  
17. (a) Burial (b) Date thereof Oct 26-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Augusta Cemetery  
18. (a) Signature of funeral director Hughes Mainfain  
(b) Address Audraisse Mo.  
19. (a) Oct 26-1947 (b) Jacob Morsinkoff  
(Date received local registrar) (Registrar's signature)

23. Signature J. P. Hullon (M.D. or other) \_\_\_\_\_  
Address Hullon mo \_\_\_\_\_

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

2-1

Date Filed 11-17-47  
District File Number

District Health Officer No. 9,

RECEIVED

---

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 Hughes Manpin  
Licensed Embalmer No. 2358  
P. O. Address Auxvasse, 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.