

No. 2
9-4-41
17-39
X29-184

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 20 1948

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28975

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 959

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town De Kalb
(c) Name of hospital or institution: State Hospital # 2 Joseph J.
(d) Length of stay: In hospital or institution 44 yrs 2 mo 12 days
In this community 44 yrs 2 mo 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Buchanan
(c) City or town De Kalb
(d) Street No De Kalb
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Mollie Wellingford

3. (b) If veteran, name war no 3. (c) Social Security No. Nil

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

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

8. AGE: Years About 80 Months msk Days msk If less than one day hr. min.

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

10. Usual occupation Nil

11. Industry or business None

12. Name Not known

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

14. Maiden name: " " (State or foreign country)

15. Birthplace: " " (State or foreign country)

16. (a) Informant: State Hospital record (b) Address: 26 Joseph J. De Kalb Mo

17. (a) Place: burial or cremation: Columbia, Mo (b) Date thereof: 9-4-48

18. (a) Signature of funeral director: Stamer Funeral Home (b) Address: St. Joseph Mo

19. (a) Date received local registrar: 9-13-48 (b) Registrar's signature: E. B. Jenkins

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 9 day 3 year 1948 hour 1 minute 15 PM

21. I hereby certify that I attended the deceased from July 1948 to 9-3-48 that I last saw her alive on 9-3-48 and that death occurred on the date and hour stated above.

Immediate cause of death: 2 months Myocarditis Duration 2 mo

Due to: Atherosclerosis 20 yrs

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

Major findings: Of operations: 93E Of autopsy:

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? (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

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

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

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 Charles M. Harman

Licensed Embalmer No. 4487

P. O. Address St Joseph

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.