

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1590

BIRTH NO. _____ REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 2001 Registrar's No. 49

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

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) Joplin		c. CITY (If outside corporate limits, write RURAL and give township) Joplin	
c. LENGTH OF STAY (in this place) 45 Years		d. STREET ADDRESS (If rural, give location) 324 North Connor Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St John's Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Viola b. (Middle) Mae c. (Last) Treganza			4. DATE OF DEATH (Month) (Day) (Year) Feb. 3, 1949		
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5. SEX Female		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH May 13, 1894		9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 54	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Carthage, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
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13a. FATHER'S NAME John W. Crawford		13b. MOTHER'S MAIDEN NAME Mollie Bowhart		14. NAME OF HUSBAND OR WIFE Harold L. Treganza	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Harold Treganza 324 N. Connor Joplin	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Breast INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
19a. DATE OF OPERATION		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 1704		

19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **1:00 AM**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. F. Hall M.D.		23b. ADDRESS Joplin Mo		23c. DATE SIGNED 2-4-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Feb. 5, 1949		24c. NAME OF CEMETERY OR CREMATORY Forest Park Cem.		24d. LOCATION (City, town, or county) (State) Joplin, Missouri	
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DATE REC'D BY LOCAL REG. 2-4-49		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS [Signature] Joplin, Mo.	
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by *[Signature]* Licensed Embalmer's Statement on Reverse Side

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 _____

James Sullivan
working under my personal supervision.

Student Embalmer No. 99

Student *James A. Sullivan*
Student Embalmer

Signed *Edwin M. Dwyer*
Licensed Embalmer No. 3566

P. O. Address *Dublin N.Y.*

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.