

FILED AUG 13 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22193**

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 828

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: "residence" before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph</u> <u>0117</u>	
c. LENGTH OF STAY (in this place) <u>324.6 m - 1 da</u>		d. STREET ADDRESS (If rural, give location) <u>3002 N-8th</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital no 2</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>May</u> b. (Middle) _____ c. (Last) <u>Twyman</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 1 1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>not given</u>	9. AGE (in years last birthday) <u>52</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

13a. FATHER'S NAME <u>W. E. Twyman</u>	13b. MOTHER'S MAIDEN NAME <u>not given</u>	14. NAME OF HUSBAND OR WIFE _____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>W. E. Twyman</u> ADDRESS <u>3002 N-8th St. St. Joseph Mo</u>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of tongue</u>		DUPLICATE TO (b) _____		
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE TO (c) <u>Dementia Precox. Nephritis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) <u>141X</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Jan 1, 1951, to Aug 1, 1951, that I last saw the deceased alive on Aug 1, 1951, and that death occurred at 10:25 a. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Forrest Thomas M.D.</u> (Degree or title)	23b. ADDRESS <u>St. Joseph Mo of State Hosp no 2</u>	23c. DATE SIGNED <u>8/1-51</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>8/2/51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Kirkville College-Osteopathy</u>
24d. LOCATION (City, town, or county) (State) <u>Kirkville Mo.</u>	24e. FUNERAL DIRECTOR'S SIGNATURE <u>Carl C. Casby</u> ADDRESS _____	DATE REC'D BY LOCAL REG. <u>Aug 6, 1951</u>

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Evan A. Clark

Licensed Embalmer No. *238*

P. O. Address *St Joseph 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.