

FILED MAR 22 1945 42

Primary Registration District No. 1000

Registrar's No. 254

1. PLACE OF DEATH: Buchanan

(a) County Buchanan

(b) City or town St Joseph Mo

(c) Name of hospital or institution: State Hospital # 2

(d) Length of stay: In hospital or institution 9-11-3

In this community Yes

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ray 11'

(c) City or town Hardman Purple h

(d) Street No. (If rural, give location) 1

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Rossie Harris

3. (b) If veteran, name war

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3 year 1945 hour 3 minute 50 P.M.

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced, married

6. (b) Name of husband or wife: William Norris

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

7. Birth date of deceased: Sept 1889

21. I hereby certify that I attended the deceased from Jan 1st 1944 to March 3 1945

that I last saw her alive on March 3 1945

and that death occurred on the date and hour stated above.

8. AGE: Years 55 Months 5 Days 11

If less than one day hr. min.

Immediate cause of death: Hemorrhage of mesenteric and bronchopulmonary artery

Due to: what caused the hemorrhage

Due to

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

Major findings: Of operations

Of autopsy

9. Birthplace: Ray Co Mo 17

(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business

MOTHER FATHER

12. Name: Charles Robinson

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

14. Maiden name: Nancy Robinson

15. Birthplace: Mo U (City, town, or county) (State or foreign country)

16. (a) Informant: William Norris

(b) Address: Hardman Mo U

17. (a) Burial, cremation, or removal: Burial

(b) Date thereof: Mar 6-1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Richmond Mo

18. (a) Signature of funeral director: E. H. ...

(b) Address: Richmond Mo

19. (a) 3-6-45 (Date received local registrar)

(b) [Signature] (Registrar's signature)

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: E. E. ... (M. D. or other)

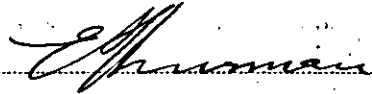
Address: State Hospital # 2 Date signed: 2/19/45

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



Licensed Embalmer No. 2077

P.O. Address... Richmond rd

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.