

Registration District No. 5883

Primary Registration District No. 5675

1. PLACE OF DEATH:

(a) County Livingston
 (b) City or town Rural Jackson Twp.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
5 1/2 miles N. W. Chillicothe, Mo.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20
 In this community Fifty years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Katharine A. Hargrave

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Dick Hargrave 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased December 28 1866
 (Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Unknown Ohio
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name George W. Mast

18. Birthplace Unknown Germany
 (City, town, or county) (State or foreign country)

14. Maiden name Melindaicorn

15. Birthplace Unknown Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dick Hargrave

(b) Address R. F. D. #3 Chillicothe, Mo.

17. (a) Burial (b) Date thereof 9-16-'40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Pleasant

18. (a) Signature of funeral director F. B. Norman Co.

(b) Address Chillicothe Mo.

19. (a) 9-16-40 (b) F. B. Norman Co.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5 1/2 miles N.W. Chillicothe, Mo.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 14
 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Aug 9
1940 to Sept 13, 1940
 that I last saw her alive on Sept 13, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy
 Due to Chr Myocarditis 5 yrs.

Due to _____
 Other conditions 93C
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

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? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
943 (Specify type of place) _____ (e) Means of injury _____

23. Signature Donald M. South (M. D. or other) _____
 Address Chillicothe Mo. Date signed 9/17/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

Elton F. Norman & E. R. Norman (2374)....., Registered Apprentice No.....
working under my personal supervision.

Signed Elton F. Norman.....

Licensed Embalmer No. 4036.....

P. O. Address Chillicothe, 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, above space should be left blank.