

No. 2
4-13-40
4-17-39
I X23139

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11916

FILED APR 15 1941

State File No. _____

Registration District No. 773

Primary Registration District No. 6018A

Registrar's No. 45

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

1. PLACE OF DEATH SAINT FRANCOIS St Francis
 (a) County FARMINGTON MISSOURI
 (b) City or town FARMINGTON MISSOURI
 (c) Name of hospital or institution STATE HOSPITAL # 4: 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED: 94
 (a) State MISSOURI (b) County ST. LOUIS
 (c) City or town UNIVERSITY CITY.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 7108 TULANE AVE.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME MATTIE CLOUD HARGRAVE

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 19, year 1941 hour 9 minute 45 A. M.

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

21. I hereby certify that I attended the deceased from January 28, 1941, to March 19, 1941; that I last saw her alive on March 18, 1941; and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOW

Immediate cause of death Cerebral Hemorrhage Duration 3 days

6. (b) Name of husband or wife JAMES ALFRED HARGRAVE 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased NOVEMBER 1st 1864. (Month) (Day) (Year)

Due to Arteriosclerosis, generalized and marked

8. AGE: Years 76 Months 4 Days 18 If less than one day _____ hr. _____ min.

Due to Chronic Myocarditis & Bundle Branch Block, Simple Degeneration 3 months

9. Birthplace EUQUALITY ILLINOIS (City, town, or county) (State or foreign country)

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy _____

10. Usual occupation AT HOME

11. Industry or business _____

12. Name JOEL COOK

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

14. Maiden name HANNA CLOUD

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

16. (a) Informant LOUIS C. HARGRAVE

(b) Address 8301 JACKSON AV; VENITA PARK CREMATION

17. (a) CREMATION (b) Date thereof MAR: 20/41 (Month) (Day) (Year)

(c) Place: burial or cremation OAK GROVE CREMATORY

18. (a) Signature of funeral director C. R. Lupton SONS INC

(b) Address 7233 DELMAR BLVD

19. (a) March 19-41 (Date received local registrar) (b) [Signature] (Registrar's signature)

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? WPA

While at work? _____ (Specify type of place)
(a) Means of injury _____

23. Signature [Signature] (M. D. or other) AMD
Address Farmington, Mo Date signed 3/20/41

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 *Clarence H. Murray*
Licensed Embalmer No. *4016*
P. O. Address *St. Louis, 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.