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FILED

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25932

Registrar's No. 9

...on District No. 720

Primary Registration District No. 6234

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

1. PLACE OF DEATH:
(a) County Putnam
(b) City or town Livonia Grant Tw
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ✓
(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:
(a) State Mo (b) County Putnam 86
(c) City or town Livonia Mo 0
(If outside city or town limits, write "RURAL")
(d) Street No. ✓
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ✓ 0 years.

3. (a) PRINT FULL NAME IRENE MABEL HARGRAVES
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex F — 1
5. Color or race W —
6. (a) Single, widowed, married, divorced 2 W —
6. (b) Name of husband or wife Geo W. Hargraves
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased March (Month) 26 (Day) 1883 (Year)

8. AGE: Years 58 | Months 3 | Days 24 | If less than one day ✓ hr. ✓ min.

9. Birthplace Crawford Co. (City, town, or county) Iowa 1 (State or foreign country)
10. Usual occupation Home work
11. Industry or business
MOTHER FATHER
12. Name John W. Pepper
13. Birthplace 41 Germany (City, town, or county) (State or foreign country)
14. Maiden name Agnes Munn
15. Birthplace Iowa (City, town, or county) (State or foreign country)
16. (a) Informant Ruth H. Rixey
(b) Address Livonia, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22-41 (Month) (Day) (Year)
(c) Place: burial or cremation St. John's Cem.
18. (a) Signature of funeral director [illegible]
(b) Address Unionville Mo
19. (a) July 23-41 (Date received local registrar) (b) E. E. McClellan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 20
year 1941 hour 10:15 minute 8 M.
21. I hereby certify that I attended the deceased from 5-27, 1941, to 7-20, 1941
that I last saw her alive on 7-20, 1941
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma ✓	1½ years
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations Complete Hysterectomy 80-20-41
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature R. W. Oley DO (~~M. D. or other~~) 2
Address Livonia Mo Date signed 7-22-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 8-41-1434
Date Filed AUG 6 1941

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 Murl E Husted

Licensed Embalmer No. 3304

P. O. Address Unionville, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-8-21-41
X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25-932

Registration District No. 720 | Primary Registration District No. 6234 | Registrar's No. 9

1. PLACE OF DEATH:
(a) County: Putnam
(b) City or town: Lincoln (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days) In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Irene M. Hargraves
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased ..... (Month) (Day) (Year)
8. AGE: Years | Months | Days | If less than one day ..... hr. ..... min.
9. Birthplace ..... (City, town, or county) ..... (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
MOTHER FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)
16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 29
year 1941 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw h. alive on ..... 19.....; and that death occurred on the date and hour stated above.
Immediate cause of death: Cerebroma 17 mitems
Due to .....
Due to .....
Other conditions (Include pregnancy within 3 months of death) .....
Major findings: Of operations .....
Of autopsy .....

Duration

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature: R. W. Alley (Med. or other) DO.
Address: Lincoln Mo. Date signed 9-24-41

SUPPLEMENTARY

48B.

Lincoln, Mo.

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