

No. 2
-1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35964**

Registration District No. **1115**

Primary Registration District No. **6021**

Registrar's No. **11**

1. PLACE OF DEATH:
 (a) County **St. Francis**
 (b) City or town **Rural - Liberty Twp.**
 (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 **Iowa** (b) County **999**
 (c) City or town **Iowa Falls** **13**
 (If outside city or town limits, write "RURAL") **0**
 (d) Street No. **—** (If rural, give location)
 (e) Citizen of foreign country? **yes** (Yes or No)
 If yes, name country **2**

3. (a) PRINT FULL NAME **MARION E. VAN FLEET**
 3. (b) If veteran, name was **In present Army** 3. (c) Social Security No. **—**
 4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **(S)**
 6. (b) Name of husband or wife **—** 6. (c) Age of husband or wife if alive **—** years

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Oct.** day **11th** year **1941** hour **3** minute **30 P. M.**
 21. I hereby certify that I attended the deceased **By Inquest duties Oct. 11** 1941
 that I last saw h. **—** alive on **—** 19 **—**
 and that death occurred on the date and hour stated above.

7. Birth date of deceased (Month) (Day) (Year)
 8. AGE: Years **25** Months Days If less than one day hr. min.
 9. Birthplace **Unknown** (City, town, or county) (State or foreign country)

Immediate cause of death **Internal Injuries** Duration
jury found the decedent came to his death by injuries received in an automobile accident which was un avoidable
 Due to **1700'**
 Other conditions (Include pregnancy within 3 months of death)

MOTHER FATHER
 11. Industry or business
 12. Name **Unknown**
 13. Birthplace **Unknown** (City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

Major findings: Of operations **—**
 Of autopsy **—**
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **none**
 (b) Address
 17. (a) **Removal** (b) Date thereof **10-12-41** (Month) (Day) (Year)
 (c) Place: burial or cremation **Iowa Falls, Ia**
 18. (a) Signature of funeral director **Funerary Home**
 (b) Address **Farlington, Mo**
 19. (a) **10-18-41** (Date received local registrar) **H. J. Rydeman** (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **Accident**
 (b) Date of occurrence **Oct 11, 1941**
 (c) Where did injury occur? **Farlington, Stuart Co** (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? **State Highway 61 - 10 mi. S of Farlington** (Specify type of place)
 While at work? **no** (e) Means of injury **Internal Injury**
 23. Signature **Lawrence Raymond Carver** (M. D. or other)
 Address **Booneville Mo** Date signed **10/12/41**

10 (Licensed Embalmer's Statement on Reverse Side)

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

NDV 29 1944

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed Johanna Reid

Licensed Embalmer No. 7238

P. O. Address. Farmington

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.