

No. 2  
4.41  
39  
29484

FILED MAR 20 1942

Primary Registration District No. 3031

State File No. ....

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Nodaway

(b) City or town Maryville  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
221 West 7th St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution .....  
(Specify whether)

In this community 32 yrs.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Nodaway

(c) City or town Maryville  
(If outside city or town limits, write "RURAL")

(d) Street No. 221 West 7th St.  
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME LUVENA FRANCES FOLAND

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex F. 5. Color or race W.

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

6. (b) Name of husband or wife Edward O. Foland

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

7. Birth date of deceased Jan 29 1866  
(Month) (Day) (Year)

8. AGE: Years 76 Months 11 Days ..... If less than one day  
hr. .... min.

9. Birthplace Andrew Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business .....

MOTHER FATHER { 12. Name George Wesley Gibson

13. Birthplace 1 Ky.  
(City, town, or county) (State or foreign country)

14. Maiden name Mary E. Violet

15. Birthplace 1 Ky.  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Vada Foland

(b) Address Kansas City, Mo.

17. (a) Burial (b) Date thereof Feb. 10, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Miriam Cemetery

18. (a) Signature of funeral director: Price Funeral Home

(b) Address Maryville, Mo.

19. (a) Feb -16-42 (b) Mamie E Clardy  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 9.  
year 1942 hour 2 minute a. M.

21. I hereby certify that I attended the deceased from Jan 20  
1942 to Feb 9, 1942  
that I last saw her alive on Feb 5, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death stroke  
following hemorrhage  
from large cerebral lobe  
Due to cyt

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? 0

While at work? ..... (Specify type of place)

(e) Means of injury .....

23. Signature H.M. Hallin Jr (M. D. or other) MO

Address Maryville Mo Date signed 2-11-42

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

556

**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..... *Clum M. Price* ..  
Licensed Embalmer No. *1822*  
P. O. Address..... *Manoyville, N.C.*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7402

Registration District No. 625

Primary Registration District No. 3031

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: nodaway

(a) County nodaway

(b) City or town marquardt  
(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 \_\_\_\_\_ (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 Lumena F Poland

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day \_\_\_\_\_ year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

(Immediate cause of death \_\_\_\_\_)

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 29 1866  
(Month) (Day) (Year)

8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day \_\_\_\_\_ min.)

Duration \_\_\_\_\_

Due to hemorrhage

Due to malignant degeneration

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations H9a

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature H. M. Haller (M. D. or other) M.D.

Address Marionville Mo Date signed 4/9/42

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

SUPPLEMENTARY

