

S. No. 2
4-5-42
5-17-43
PI X-227

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32053

State File No.

FILED OCT 9 1943 7

Registration District No. 7

Primary Registration District No. 5-696

Registrar's No. 106

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:
7 miles North West-Chillicothe, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 74 years (Specify whether
In this community 74 years years, months or days)

3. (a) PRINT FULL NAME David Hargrave

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

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

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

7. Birth date of deceased March 30 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

74 5 8 hr. _____ min.

9. Birthplace Livingston County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

MOTHER FATHER

12. Name John Hargrave

13. Birthplace Livingston County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Gibbs

15. Birthplace Livingston County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Earl Cooper

(b) Address R. R. # Chillicothe, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-'43
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Pleasant Cemetery

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

(b) Address Chillicothe, Missouri

19. (a) Sept 10-43 (Date received local registrar) (b) Geo Elha Cozzy (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston

(c) City or town (RURAL) Jackson Twp.
(If outside city or town limits, write "RURAL.")

(d) Street No. 7 Miles N. W. Chillicothe, M.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 8th.
year 1943 hour 8:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from Sept 7 to Sept 7 1943
that I last saw him alive on Sept 7 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chc Myocarditis Nephritis

Due to _____

Due to _____

Other conditions (Include conditions within 3 months of death) Adenoma of Prostate

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? _____

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

23. Signature Geo Elha Cozzy (M. D. or other) _____
Address Chillicothe Date signed 9/14/43

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

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.....

..... E. R. Norman, Registered Apprentice No.....
working under my personal supervision.

Signed..... ER Norman

Licensed Embalmer No..... 2374

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, fact should be so stated above.