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DOM-2-43  
ev. 5-17-39  
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19016

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

FILED JUN 14 1944

Registration District No. 315

Primary Registration District No. 6067

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

1. PLACE OF DEATH:

(a) County ST CLAIR

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

(c) Name of hospital or institution: 1  
(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 MISSOURI (b) County ST CLAIR

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

(d) Street No. SPEEDWELL TWP  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CHARLEY GARVER

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st  
year 1944 hour 6 minute 30.9 M.

4. Sex MALE 5. Color or race White

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

6. (b) Name of husband or wife LUCY GARVER

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased: MARCH 31 1888  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 1, 1944 to May 12, 1944  
that I last saw him alive on May 12, 1944  
and that death occurred on the date and hour stated above.

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

69 1 12 hr. \_\_\_\_\_ min.

Immediate cause of death: Partial Stenosis

9. Birthplace: \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation: FARMER

Due to: Extremely High Blood Pressure, Several Years Standing

11. Industry or business \_\_\_\_\_

12. Name: Theodore Garver

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

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

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

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

14. Maiden name: Mary Jane Shade

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant: Mrs Lucy Garver

(b) Address: P.O. El Dorado Springs, Mo.

17. (a) Burial (b) Date thereof: 5-17-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence: NO

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(c) Place: burial or cremation: City Country El Dorado

18. (a) Signature of funeral director: Swim Siders

(b) Address: El Dorado Springs, Mo.

(d) Did injury occur in or about home, on farm, in industrial place, in public place? NO

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

19. (a) May 17, 1944 (b) L.H. Kordrich  
(Date received local registrar) (Registrar's signature)

23. Signature: J.W. Richardson (M. D. or other) \_\_\_\_\_  
Address: Jefferson Mo. Date signed: 5-23-44

111-21 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 7,

District File Number

5-44-747

Date Filed

6-8-12-44

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

*[Handwritten Signature]*

Licensed Embalmer No.

2034

P. O. Address

*[Handwritten Address]*

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.