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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED DEC 6 1945**

STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

37384

State File No. \_\_\_\_\_

Registration District No. 142

Primary Registration District No. 1355

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town "Rural" Chapin Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community Since 1929 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell  
(c) City or town Mountain View mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural 0-4 Mountain  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Elizabeth Desgranges

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, 2 divorced Widowed

6. (b) Name of husband or wife Peter Desgranges 6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased Aug 21 1870  
(Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days 11 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Belmont Co Ohio (City, town, or county) (State or foreign country)

10. Usual occupation Home Wife

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

12. Name Alfred Cusans

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

14. Maiden name Jane Van Fossen

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

16. (a) Informant Olivier Desgranges  
(b) Address Mountain View mo

17. (a) Removal (b) Date thereof 12-2-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wayfield mo  
(d) Signature of funeral director Chas E. Mean  
(e) Address 1201 1/2 E. 4th

19. (a) 12-3-45 (b) Laura Mitchell  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 1 year 1945 hour 7 minute 20 A. M.

21. I hereby certify that I attended the deceased from Nov 21 1945 to Nov 30 1945; that I last saw her alive on Nov 30 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Hypertension

Due to \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy gpa

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

23. Signature Stanley Barium (M. D. or other) Dr.  
Address Mountain View Date signed 12-1-45

1456

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

**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 \_\_\_\_\_

working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. 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.**