DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 21 1945

State File No. 41630

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 61

1. PLACE OF DEATH:

(a) County Lafayette

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

(c) Name of hospital or institution: N 17th St. 1 (If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette 54

(c) City or town Lexington, MO 3 (If outside city or town limits, write "RURAL")

(d) Street No. N. 17th St 2 (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME ELIZABETH JARVIS

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

4. Sex Fe 1 | 5. Color or race W | 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife A. W. Jarvis 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased May (Month) 20 (Day) 1866 (Year)

8. AGE:

Years	Months	Days	If less than one day
79	5	22	hr. min.

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

10. Usual occupation at home

11. Industry or business

FATHER
12. Name John Seaton
13. Birthplace Ohio 1 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ellen Lambright
15. Birthplace Va 1 (City, town, or county) (State or foreign country)

16. (a) Informant A. W. Jarvis

(b) Address Lexington, MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-45 (Month) (Day) (Year)

(c) Place: burial or cremation Lexington, MO

18. (a) Signature of funeral director Forrest F. Tempel

(b) Address Lexington, MO

19. (a) 11 Dec 1945 (Date received local registrar) (b) Minnie E. Eardbrook (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Nov day 12 year 1945 hour 9 minute A M.

21. I hereby certify that I attended the deceased from 30 Oct 1945, to 12 Nov 1945 that I last saw her alive on 11 Nov 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial & hypostatic pneumonia	
Due to Fracture rt hip (Fall in home)	
Due to	
Other conditions Fracture rt hip (Include pregnancy within 3 months of death)	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations none

Of autopsy none

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 54

(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 0

23. Signature Ben H Brasher (M. D. or [illegible])

Address Lexington, MO Date signed 11/12/45

1619

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 12-17-42

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 Geo. McKean

Licensed Embalmer No. 2983

P. O. Address Lewisville, W

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 61

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Lexington
(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 Elizabeth Jarvis

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 30 (Day) 1864 (Year)

8. AGE: Years 79 Months 5 Days 22 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Nov Day 2 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions Fracture rt hip (intertrochantric) (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

1860 17 18

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) Fall - Home

(b) Date of occurrence 10-29-45

(c) Where did injury occur? Lexington (City or town) Lafayette (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? Yes (e) Means of injury Fall

23. Signature Ben H B Rasher (M. D. ~~or other~~)

Address Lexington Mo Date signed 12-24-45

41630