

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16433

State File No. _____

FILED

JUN 13 1946

Registration District No. 1323

Primary Registration District No. 3022

Registrar's No. 60

1. PLACE OF DEATH:

(a) County HARRISON
 (b) City or town BETHANY
 (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) Month of stay: In hospital or institution _____ (Specify whether
 In this community 15 DAYS
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48
 (c) City or town KANSAS CITY, Mo. 3
 (If outside city or town limits, write "RURAL")
 (d) Street No. 616 EAST 15TH ST. 8
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MINERVA YEA HARDELL

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOW
 6. (b) Name of husband or wife WILLIAMS 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 6 28 1860
 (Month) (Day) (Year)

8. AGE: Years 85 Months 7 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER

12. Name MILTON HIGGINS

13. Birthplace DO NOT KNOW
 (City, town, or county) (State or foreign country)

14. Maiden name BROWN

15. Birthplace DO NOT KNOW
 (City, town, or county) (State or foreign country)

16. (a) Informant: Ray McClure

(b) Address Bethany, Mo.

17. (a) BURIAL (b) Date thereof 5/12/46
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: MIRIAM CEMETERY

18. (a) Signature of funeral director: M. B. Haco

(b) Address Bethany, Mo.

19. (a) May 13-46 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 9
 year 1946 hour 8 minute 12 P.M.

21. I hereby certify that I attended the deceased from April 25, 1946, to May 9, 1946;
 that I last saw her alive on May 9, 1946;
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion -
Resulting from Coronary atherosclerosis
 Duration 1 1/2 hrs

Due to _____
 Due to _____

Other conditions Chronic Myocarditis 4 years
 (Include pregnancy within 8 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

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) Means of injury _____
 23. Signature [Signature] (M. D. or other) _____
 Address Bethany, Mo. Date signed 5/11/46

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *Shonston H. Haas*.....
Licensed Embalmer No. *2861*.....
P. O. Address..... *Bethany, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Time
Registrar's No. 60

Registration District No. 123 Primary Registration District No. 3023

1. PLACE OF DEATH:
(a) County Harrison
(b) City or town Bethany
(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

3. (a) PRINT FULL NAME Minerva V. Hadel
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: June 28
(Month) (Day) (Year)
8. AGE: Years 85 Months _____ Days _____ (If less than one day) _____ hr. _____ min.

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

10. Usual occupation Housewife
11. Industry or business Home

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) Zola Burris
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May 1946 year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

16433