

**FILED OCT 8 1946** STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 93

Registration District No. 114 Primary Registration District No. 4186

**1. PLACE OF DEATH:**

(a) County Franklin

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

(c) Name of hospital or institution: North Side Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 weeks  
(Specify whether years, months or days)

In this community 23 years

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Franklin 36

(c) City or town Leslie RR # II  
(If outside city or town limits, write "RURAL") 0

(d) Street No. \_\_\_\_\_  
(If rural, give location) 0

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

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** JESSIE LENA HOVELMAN

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

3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept day 30 year 1946 hour 11:05 minute \_\_\_\_\_

21. I hereby certify that I attended the deceased from Aug 19 1946 to Sept 30 1946

that I last saw her alive on Sept 30 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration years

4. Sex female 5. Color or race white

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Wm J. Hovelmann 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Nov 3 1900  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>45</u>	<u>10</u>	<u>27</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

**MOTHER FATHER**

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

12. Name Thomas J. Arnold

13. Birthplace Port Hudson Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Westerman

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

16. (a) Informant William F. Hoerchmann

(b) Address Leslie Mo, RR #2

17. (a) Burial (b) Date thereof Oct 4-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sullivan, Ad Jell

18. (a) Signature of funeral director E. Meyer

(b) Address Leslie Mo

19. (a) 10-3-46 (b) O. A. Paster  
(Date received local registrar) (Registrar's signature)

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

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

Other conditions 124B  
(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings:  
Of operations none

Of autopsy none

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 Samuel R. Baum (M. D. or other) \_\_\_\_\_

Address Leslie Mo Date signed 10/3-46

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

28782

36  
4  
0

**RECEIVED**  
District Health Officer No. 9,  
District File Number  
~~Date Filed 10-7-46~~

OCT 21 1946

**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 Earl A. Hittig  
Licensed Embalmer No. 3385  
P. O. Address New Haven Conn

**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.**