

FILED MAR 1 1948 12

Primary Registration District No. 6057

1. PLACE OF DEATH:  
 (a) County St. Clair  
 (b) City or town Rural Center Twp  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Home 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 13 yrs (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. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Olive Alvira Parviance  
 3. (b) If veteran, name war None  
 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Nov day 27  
 year 1946 hour 1 minute 2 P.M.

4. Sex female 5. Color or race white  
 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife John S. Parviance  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: Feb 13 1862  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 10, 1946, to November 26, 1946, that I last saw her alive on November 14, 1946, and that death occurred on the date and hour stated above.

8. AGE: Years 84 Months 9 Days 12  
 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min

Immediate cause of death arteriosclerosis  
 Due to Senility  
 Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations 97  
 Of autopsy \_\_\_\_\_

10. Usual occupation Housekeeping

MOTHER FATHER  
 11. Industry or business \_\_\_\_\_  
 12. Name George W. Cortwright  
 13. Birthplace Ohio  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Julia Bramon  
 15. Birthplace Ohio  
 (City, town, or county) (State or foreign country)

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Essie M. Parks  
 (b) Address Orcola Mo #3

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof 11-29-1946  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Appletown City Mo

While at work? \_\_\_\_\_ (Specify type of place)  
 (c) Means of injury 2

18. (a) Signature of funeral director Frank J. W.  
 (b) Address Appletown City Mo  
 19. (a) 12-10-46 (b) Frank J. W.  
 (Date received local registrar) (Registrar's signature)

23. Signature P. Frank Todd (M.D. or other)  
 Address Orcola Missouri Date signed 11/28/46

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

42571

Case  
19164-1

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 ME  
on the 27-day of Nov 1946, Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed Frank Lee

Licensed Embalmer No. 1079

P. O. Address Appleton City Wis

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.