No. 2
-12-45
-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 3 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4279

Registration District No. _____ Primary Registration District No. 4099 Registrar's No. 33

1. PLACE OF DEATH:
(a) County Cass
(b) City or town Pleasant Hill
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 714 Pine
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cass
(c) City or town Strasburg, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Alva Burton Markel
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Cora A. Markle
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Jan. (Month) 11 (Day) 1862 (Year)
8. AGE: Years 85 Months 1 Days 0 If less than one day _____ hr. _____ min.
9. Birthplace Danville (City, town, or county) Ill. (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name John Markle
13. Birthplace _____ (City, town, or county) Germany (State or foreign country)
MOTHER 14. Maiden name Hannah Hodkins
15. Birthplace ? (City, town, or county) ? (State or foreign country)
16. (a) Informant Mrs Harry Sechrest
(b) Address Pleasant Hill, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-47 (Month) (Day) (Year)
(c) Place: burial or cremation Strasburg, Mo.
18. (a) Signature of funeral director Allen Brownfield
(b) Address Pleasant Hill, Mo.
19. (a) 2-26-1946 (Date received local registrar) (b) Laura J. Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 11 year 1947 hour 2:25 minute A M.
21. I hereby certify that I attended the deceased from 6 Feb. 1947, to 11 Feb 1947 that I last saw him alive on 11 Feb. 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Embolus	3 Days
Due to Auricular Fibrillation	20 min
Due to Arteriosclerosis generalized	3 Yrs.
Other conditions (Include pregnancy within 3 months of death) Ununited Fracture Right Hip	

Major findings:
Of operations
Of autopsy None Performed

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 place)
While at work? (e) Means of injury

23. Signature Alfred W. Ehlmann (M. D. or other) MD
Address Pleasant Hill, Mo. Date signed 21 Feb '47

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(Licensed Embalmer's Statement on Reverse Side)

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

By me 2-11-47, Registered Apprentice No.

working under my personal supervision.

Signed Allen Brownfield

Licensed Embalmer No. 3785

P. O. Address Pleasant Hill 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.

No. 2B
—3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4279 March

Registration District No. 59 Primary Registration District No. 4099 Registrar's No. 33

1. PLACE OF DEATH:

(a) County: Cass

(b) City or town: Pleasant Hill
(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 years, months or days)
In this community

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: Alva B. Markel

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: M

6. (b) Name of husband or wife

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

7. Birth date of deceased: Jan (Month) 11 (Day) 1882 (Year)

8. AGE: Years 65 Months 1 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Ill (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 Jan Day 11 year 1947 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.

Immediate cause of death — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)
Old malunited fracture, R hip

Major findings:
Of operations (22 yrs ago) - home

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: None

(a) Accident, suicide, or homicide (specify) None

(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 place)

While at work? (e) Means of injury

23. Signature Alfred W. Ellland (M. D. or other) MD.

Address Pleasant Hill Date signed 3-12-47

SUPPLEMENTARY