No. 2
2-45
17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 13 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25113

Registration District No. 298 Primary Registration District No. 6024 Registrar's No. 13

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Rural Polk
(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 29 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray 89

(c) City or town Rural 0
(If outside city or town limits, write "RURAL")

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

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

If yes, name country

3. (a) PRINT FULL NAME MINNIE ESTELLA CLEVENGER

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 widowed

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. (Month) 16 (Day) 1870 (Year)

8. AGE: Years 77 Months 7 Days 25 If less than one day ..... hr. ..... min.

9. Birthplace Knoxville (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Andrew Arnate 0
13. Birthplace (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Marovia Georgia 0
15. Birthplace (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Mrs. Tom Cates
(b) Address Lawson, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July (Month) 14 (Day) 1947 (Year)
(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director Garman-Prichard
(b) Address Lawson, Mo.

19. (a) July 13, 1947 (Date received local registrar) (b) Mrs. Raymond Grove (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11th year 1947 hour 8:00 minute P. M.

21. I hereby certify that I attended the deceased from August 10, 1946, to July 11th, 1947 that I last saw her alive on July 11th, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis sudden
Hypertension, Arteriosclerosis

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

94A

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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature S R M Crocker (M. D. or other) M. D.

Address Excelsior Springs, Mo. Date signed 7/12/47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 8-12-47

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 E. E. White

Licensed Embalmer No. 468

P. O. Address Excelsior Spg., 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
M—3-45
I 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. 44 9

Registration District No. 298 Primary Registration District No. 6024 Registrar's No. 18

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Rural
(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 Minnie E. Clevenger

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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. 16 (Month) (Day) (Year)

8. AGE: Years 77 Months 7 Days If less than one day hr. min.

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

10. Usual occupation Housewife

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) Mrs. Raymond Hope (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. Day 16 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)

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

5-25113