

No. 2
1-2-43
17-39
1-2-43

FILED DEC 3 1947

State File No.

Registration District No.

Primary Registration District No. 5009 4003

Registrar's No. 320

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Gibbs

(c) Name of hospital or institution: Nursing Home
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 2 mo's 19 days
(Specify whether years, months or days)

In this community 3 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

(c) City or town Kirksville
(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 Alice Le Van

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife George F. Le Van

6. (c) Age of husband or wife if alive 6 years 1860 (Year)

7. Birth date of deceased July (Month) 6 (Day) 1860 (Year)

8. AGE: Years 87 Months 4 Days 6
If less than one day hr. min.

9. Birthplace Wheeling West Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business

MOTHER FATHER } 12. Name Joseph Funk

13. Birthplace Wheeling, West Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Taylor

15. Birthplace West Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Pearl Funk

(b) Address Kirksville, Missouri

17. (a) Burial (b) Date thereof 11/13/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Linnville Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address Kirksville, Missouri

19. (a) 11-27-47 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12
year 1947 hour 4:00 minute A: M.

21. I hereby certify that I attended the deceased from Nov 11 1947 to Nov 12 1947
that I last saw her alive on Nov 11 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy Duration 24 hrs

Due to

Due to

Other conditions Fractured right hip?
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN
ADDITIONAL
SUFFICIENT
INFORMS
REGISTERS
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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place) (e) Means of injury 0

23. Signature [Signature] (M. D. or other) MD

Address Kirksville, Mo Date signed 11-17-47

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

RECEIVED

District Health Officer No. 10

District File Number 12-47-164

Date Filed DEC-21-1947

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 William C. Mendenkall

Licensed Embalmer No. 4449

P. O. Address Kirkville, 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. 100
Registrar's No. 320

Registration District No. 1 Primary Registration District No. 4003

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Sebby
(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)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____
year 194 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____
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 _____

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 _____
(Month) (Day) (Year)
8. AGE: Years 87 Months _____ Days _____
If less than one day hr. _____ min. _____

Duration _____
Accident occurred
at 8 o'clock place in
private home where
she was staying. She
felt I think she had a
cerebral hemorrhage
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: Accident occurred
in a small
town, (Libes Mo)
Of autopsy _____

9. Birthplace W Va.
(City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
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) _____
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

S-36950

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