DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 15 1949

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31227

Registration District No. 251 Primary Registration District No. 4371 Registrar's No. 238

1. PLACE OF DEATH:
(a) County Nodaway
(b) City or town Elmo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ford Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Five days (Specify whether years, months or days)
In this community 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Iowa (b) County Page 99
(c) City or town College Springs, Iowa 12 (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 CLARA JANE HARTMAN
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife J. W. Hartman
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Dec. (Month) 3 (Day) 1893 (Year)

8. AGE: Years 55 (fifty five) Months 10 Days 1 If less than one day hr. min.
9. Birthplace Don't Know State (City, town, or county) USA (State or foreign country)
10. Usual occupation House wife
11. Industry or business

MOTHER
12. Name Carroll
13. Birthplace Don't Know State (City, town, or county) U.S.A (State or foreign country)

FATHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant J. W. Hartman
(b) Address College Springs Iowa
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6th 1949 (Month) (Day) (Year)
(c) Place: burial or cremation Rose Hill Cemetery Shenandoah Iowa
18. (a) Signature of funeral director L. M. Levinson
(b) Address College Springs Iowa
19. (a) 10-8-49 (Date received local registrar) (b) Beas (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day fourth year 1949 hour 9 minute 05 A.M.
21. I hereby certify that I attended the deceased from Sept 28, 1949 to Oct 4, 1949 that I last saw him alive on Oct 4, 1949; and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Congestive heart failure due to renal failure due to
Due to: chronic interstitial Nephritis.
Due to:
Other conditions (Include pregnancy within 3 months of death): 434

Duration: 4 days; years

Major findings:
Of operations: none
Of autopsy: none

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 Harvey N. Ford (M.D. or other) MD
Address Elmo Mo. Date signed Oct 4-49

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
OCT 10 1949
DISTRICT
HEALTH OFFICE
CAMERON, MO.

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 L. M. Stevenson

Licensed Embalmer No. 1727

P. O. Address College Springs Iowa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.