

FILED NOV 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33267

State File No.

BIRTH NO. _____ REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 4100 Registrar's No. 144

1. PLACE OF DEATH a. COUNTY <u>Coass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Coass</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Strasburg</u>	c. LENGTH OF STAY (In this place) <u>17 yr</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Strasburg</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) <u>JENNIE</u> b. (Middle) <u>FRANCES</u> c. (Last) <u>HARGYAVE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 28, 1949</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 22, 1874</u>
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u>6</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>Joseph D. Picketts</u>		13b. MOTHER'S MAIDEN NAME <u>Mary A. Plank</u>	14. NAME OF HUSBAND OR WIFE <u>BEN FRANK HARGYAVE</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>HARRY D. HARGYAVE Arlington Va.</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Endarteritis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19c. INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 29, 1949</u> , to <u>Oct 28, 1949</u> , that I last saw the deceased alive on <u>Oct 28, 1949</u> , and that death occurred at <u>11:30 P. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>W. Beckeman</u>		23b. ADDRESS <u>M.D. Strasburg, Mo</u>	23c. DATE SIGNED <u>10/28/49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Oct. 29, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>
DATE REC'D BY LOCAL REG. <u>Nov. 5, 1949</u>	REGISTRAR'S SIGNATURE <u>Laura J. Jones</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Stuart M. Blue</u>	ADDRESS <u>Kansas City Mo.</u>

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

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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Charles H. Stuchman

Licensed Embalmer No. 4560

P. O. Address RC

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.