

THE DIVISION OF HEALTH OF MISSOURI  
FILED MAR 24 1951 STANDARD CERTIFICATE OF DEATH

8289

State File No. ....

0470  
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BIRTH NO. _____		REG. DIST. NO. <u>144</u>		PRIMARY REG. DIST. NO. <u>5562</u>		Registrar's No. <u>9</u>	
1. PLACE OF DEATH a. COUNTY <u>Iron</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Iron</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural-Asadia</u>		c. LENGTH OF STAY (in this place) <u>1 mi/mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural-Asadia</u>		0470	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>The Home of the Deaf</u>				d. STREET ADDRESS (If rural, give location) <u>1 1/2 mi East on Highway 70</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Margaret</u>			b. (Middle) <u>Van</u>		c. (Last) <u>Next</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 21, 1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Sept. 19, 1865</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. <u>85 6 2</u>	
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>her home</u>		11. BIRTHPLACE (State or foreign country) <u>Thomas County Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Robert Eriley Hovick</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Brady</u>		14. NAME OF HUSBAND OR WIFE <u>L.P. Van Next</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, state war or dates of service) <u>no.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Carl H. Bursey, Fronton, Mo</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Favorable bilateral bronchial pneumonia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>chronic arthritis</u>  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>  <u>?</u>  <u>491X</u>  <u>?</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					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) (Min.)		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>3-7</u> , 19 <u>51</u> , to <u>3-21</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>3-14</u> , 19 <u>51</u> , and that death occurred at <u>6:10 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>R. E. J. Farland, M.D.</u>			23b. ADDRESS <u>Fronton, Missouri</u>		23c. DATE SIGNED <u>3-21-51</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>March 22, 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u>		
DATE REC'D BY LOCAL REG. <u>Mar. 22, 1951</u>		REGISTRAR'S SIGNATURE <u>Mrs. Arvia Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harding Funeral Home</u>		ADDRESS <u>Jonesburg Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

MAR 23 1951

DISTRICT HEALTH OFFICE No. 6

Case No. ....

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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 *Arnel G. White* .....

Licensed Embalmer No. *3012* .....

P. O. Address *Quinton, 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.