

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

18920

State File No. _____

Registration District No. 508

Primary Registration District No. 5674

Registrar's No. 68

1. PLACE OF DEATH:

(a) County Livingston
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1/2 mile S. Chillicothe-Highway 36-65
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether)
In this community Thirty years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston
(c) City or town Chillicothe
(If outside city or town limits, write "RURAL")
(d) Street No. Herriman
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME James H. O'Haver 160

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alice M. O'Haver 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased October 27 1888
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>6</u>	<u>12</u>	hr. _____ min. _____

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

10. Usual occupation Carpenter

11. Industry or business _____

12. Name Solomon O'Haver

13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Margarette McCormick

15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. J. H. O'Haver

(b) Address 12 Herriman Chillicothe, Mo.

17. (a) Burial (b) Date thereof 5-11-'40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wheeling

18. (a) Signature of funeral director F. B. Norman

(b) Address Chillicothe, Mo.

19. (a) 5-10-40 (b) F. B. Norman, MD.
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 9 day
year 1940 hour 8:45 minute _____ M.

21. I hereby certify that I attended the deceased from never
attended him, to _____, 19____;
that I last saw him alive on Apr. 30, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris for minutes
(From History)

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy no

Duration

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? _____

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While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Em Grass (M. D. or other) _____

Address Chillicothe, Mo. Date signed May 11 1940

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

Elton F. Norman & E. R. Norman (2374) Registered Apprentice No.....
working under my personal supervision.

Signed Elton F. Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, 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, above space should be left blank.