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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 1 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

33972

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4295

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Conley Clinical Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether

In this community 26 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 3

(d) Street No. 3732 Woodland Ave. (If rural, give location) 8

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Mrs Antoinie H. Van Booven

3. (b) If veteran, (Antoinie H. Struttman) Social Security name war No No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 2 Widow

6. (b) Name of husband or wife William Van Booven 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan. 9, 1869 (Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 27 If less than one day hr. min.

9. Birthplace Rhineland, Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name No record
13. Birthplace No record (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name No record
15. Birthplace No record (City, town, or county) 9 (State or foreign country)

16. (a) Informant J. R. Van Booven

(b) Address 3629 Paseo Blvd.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 9, 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Slater, Mo.

18. (a) Signature of funeral director Thos. E. Quirk Funeral Home

(b) Address 4316 Troost Ave.

19. (a) 10-8-43 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 6 year 1943 hour 4 minute 35 pM.

21. I hereby certify that I attended the deceased from Oct. 5, 1943, 19, to Oct 6, 1943 that I last saw her alive on Oct. 6, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis - Acute

Due to Diabetic Coma

Due to 61

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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? (Specify type of place)

Home at work? (e) Means of injury

23. Signature Charles Glass (M. D. or other) D-O

Address 3301 Woodland Date signed 10/6/43

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.