

FILED MAY 11 1944

State File No. \_\_\_\_\_

Registration District No. 257

Primary Registration District No. 3048

Registrar's No. 56

1. PLACE OF DEATH:

(a) County 770d away  
(b) City or town Manquille Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution St. Francis  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community about 5 hrs. years, months or days)

3. (a) PRINT FULL NAME Cora Adell Provance

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Douglas Provance Deceased 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 3 - 1870  
(Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 27 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Adell County Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Daniel A. Buncy

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

14. Maiden name Hilda White

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

16. (a) Informant Max John M. Gray

(b) Address Pickering Mo

17. (a) Burial (b) Date thereof 4-1-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wepth Grove @ Trenton Mo

18. (a) Signature of funeral director Campbell Funeral Home

(b) Address Manquille Missouri

19. (a) 3-30-44 (b) Amy Barber  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gundy 40  
(c) City or town Trenton 1  
(If outside city or town limits, write "RURAL") 2  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 30  
year 1944 hour 4 minute a M.

21. I hereby certify that I attended the deceased from March 20 1944 to March 30 1944  
that I last saw h. or alive on March 28 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Disease of coronary arteries Duration 10 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 940

Major findings: Of operations No operation

Of autopsy No autopsy

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? \_\_\_\_\_

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

23. Signature Eugene L. Lowrey (M. D. or other) MD

Address Pickering Mo Date signed 3-30-44

MOTHER FATHER

**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

*Marjorie Lulu Campbell*, Registered Apprentice No. *360*  
working under my personal supervision.

Signed

*William Campbell*

Licensed Embalmer No.

*2620*

P. O. Address

*Manville W.*

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

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

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. May  
Registrar's No. 56

Registration District No. 251

Primary Registration District No. 3048

1. PLACE OF DEATH:

(a) County nodaway  
(b) City or town mayfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

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

In this community.....  
years, months or days)

3. (a) PRINT FULL NAME Cora A. Provanice

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... year.....

7. Birth date of deceased June 3 1918  
(Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 12 If less than one day..... min.

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar)..... (b) Amy Barber (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

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

(d) Street No..... (If rural, give location)

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Year 1946 Day 30 Minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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?.....

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

23. Signature..... (M. D. or other)..... Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

1939

15350