No. 2
8-43
7-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 5 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2003

Registration District No. 71 — Primary Registration District No. 3012 — Registrar's No. 12

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Excelsior Springs Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 hrs (Specify whether
In this community unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Iowa (b) County 999
(c) City or town Spencer 13
(If outside city or town limits, write "RURAL")
(d) Street No. Dont Know
(If rural, give location)
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MARY A. CAUVEL

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

4. Sex Female
5. Color or race white
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased About (Month) 1878 (Day) (Year)

8. AGE: Years 67 | Months — | Days — | If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Lenora Biggs
(b) Address Hankinson N. D.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-30-45 (Month) (Day) (Year)
(c) Place: burial or cremation Spencer Ia
18. (a) Signature of funeral director Herbert Hope
(b) Address Excelsior Springs Mo
19. (a) 1-30-45 (Date received local registrar) Miss Sadie Redman (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day 27 year 1945 hour 845 minute P M.
21. I hereby certify that I attended the deceased from Jan 27-45 19 P.M. to Jan 27 To 845 P.M. 1945
that I last saw her alive on Jan 27 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Occlusion	6 hrs
Due to Chronic angina	
Due to Chronic arterial Sclerosis	
Other conditions age 94a (Include pregnancy within 3 months of death)	

Major findings:
Of operations none made
Of autopsy none made

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)
While at work? (e) Means of injury —
23. Signature John F. Grace (M.D. or other) M.D.
Address Excelsior Springs Mo Date signed Jan 29/45

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No.
District File Number
Date Filed 5-2-45

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 James A Moles

Licensed Embalmer No. 3296

P. O. Address Ex Springs M

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.

No. 2B
—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 12

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Excelsior Springs
(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)

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

3. (a) PRINT FULL NAME Mary A. Cauvel
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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) 1888 (Year)
8. AGE: Years 67 Months — Days — If less than one day hr. min.
9. Birthplace (City, town, or county) unk (State or foreign country)
10. Usual occupation (no more information)
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
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) 1-3-45 (Date received local registrar) (b) Mrs Sadie Redman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 27
year 1945 hour 8 minute M.
21. I hereby certify that I attended the deceased from
, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

S-2063