. No. 2
1—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

27244

State File No.

FILED AUG 23 1945

Registration District No. 99

Primary Registration District No. 5380

Registrar's No. 5-2

1. PLACE OF DEATH:
(a) County DeKalb
(b) City or town Stewartsville (If outside city or town limits, write "RURAL" and name of township) Missouri
(c) Name of hospital or institution: Washington Twp
At home (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 Missouri (b) County DeKalb 32
(c) City or town Stewartsville (If outside city or town limits, write "RURAL") Rural c
(d) Street No. (If rural, give location) c
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Cora Hovenga
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband ~~or wife~~ John E Hovenga
6. (c) Age of husband ~~or wife~~ If alive 69 years
7. Birth date of deceased May (Month) 29 (Day) 1882 (Year)

8. AGE: Years 63 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Macon (City, town, or county) Missouri (State or foreign country)
10. Usual occupation House wife
11. Industry or business

MOTHER FATHER
12. Name Frederick Palfrey
13. Birthplace South Wales (City, town, or county) England (State or foreign country)
14. Maiden name Hannah Louise Ebaing
15. Birthplace Albany (City, town, or county) New York (State or foreign country)

16. (a) Informant Mrs Everett J Boyles
(b) Address Gaston, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Maple Grove
18. (a) Signature of funeral director W. F. Myers
(b) Address Stewartsville Mo
19. (a) 7-21-45 (Date received local registrar) (b) John Cloyd (Registrar's signature)

1378

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11
year 1945 hour 4 minute 30 M.
21. I hereby certify that I attended the deceased from April 12, 19XX, to July 11, 19XX
that I last saw her alive on July 9, 19XX
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Carcinoma of Pancreas

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations — Hx Ca

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. S. Gale (M. D. ~~or other~~)
Address Osborn Mo Date signed July 12 XX

AUG 31 1955

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 F. G. Tyson

Licensed Embalmer No. 952

P. O. Address Stewartsville 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.

S. No. 2B
5M—3-45
I X43880

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. Sept

Registration District No. (99) Primary Registration District No. (5380) Registrar's No. 32

1. PLACE OF DEATH:

(a) County (DeKalb) Rural Washington Twp
(b) City or town (Stewartsville Mo)
(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 Mo (b) County DeKalb
(c) City or town Stewartsville Rural Washington Twp
(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 Cora Houlinga

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 M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased May 29 (Month) (Day) 68 (Year)

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER / FATHER

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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day
year 1975 hour 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

SUPPLEMENTARY

5-27244