

FILED DEC 21 1945 STANDARD CERTIFICATE OF DEATH

State File No. 41619

Registration District No. 170

Primary Registration District No. 5627

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede
 (b) City or town Competition
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1

(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 MARGARETTA ANN VAN STAVERN

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 widowed

(b) Name of husband or wife Cornelius Van Stavern 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 25 1856
 (Month) (Day) (Year)

8. AGE: Years 89 Months 6 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Hiram Hoggett 13. Birthplace unknown (City, town, or county) (State or foreign country)

14. Maiden name Mary Jane Miller 15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Orr Van Stavern (b) Address Competition mo.

17. (a) Burial (b) Date thereof 8-29-45 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation M^c Bride

18. (a) Signature of funeral director W.E. Holman (b) Address Lebanon mo.

19. (a) 9-10-45 (b) Dr. H. Frankenberg (Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month Aug day 27 year 1945 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from 8-17 1945 to 8-27 1945 that I last saw her alive on 8-17 1945 and that death occurred on the date and hour stated above.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede
 (c) City or town Competition
 (If outside city or town limits, write "RURAL")

(d) Street No. Rural (If rural, give location)(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 27 year 1945 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from 8-17 1945 to 8-27 1945 that I last saw her alive on 8-17 1945 and that death occurred on the date and hour stated above.

Immediate cause of death myocarditisDue to Hypertension & Age

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Be

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 0

23. Signature Dr. Lindsey (M. D. or other MD)
 Address Conway Date signed 9-10-45

Received

Laclede County Health Unit

File No. 11-45-162

Date Filed 12/18/40

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 Dersey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, Mo.

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.