

STANDARD CERTIFICATE OF DEATH

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

**FILED FEB 8 1946**  
Registration District No. 82

Primary Registration District No. 3017

Registrar's No. 108

1. PLACE OF DEATH:

(a) County Cooper

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

(c) Name of hospital or institution 8 hr 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howard

(c) City or town Rural  
(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 MARGARETTE K. RAVENEL

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 29  
year 1945 hour \_\_\_\_\_ minute 10:30 P.M.

21. I hereby certify that I attended the deceased from 12-29 1945 to 12-29 1945  
that I last saw her alive on 12-29 1945  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased May 4 1862  
(Monthly) (Day) (Year)

Immediate cause of death Coronary occlusion

Due to arteriosclerosis venularum

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>7</u>	<u>27</u>	hr. _____ min.

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

10. Usual occupation at Home

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: Of operations none

Of autopsy none

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

12. Name Joseph Kenney

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

14. Maiden name Margaret Clark

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

16. (a) Informant Mrs. J. M. Aubrey

(b) Address Rochport Mo

17. (a) Reburial (b) Date thereof 12/29/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walnut Grove

18. (a) Signature of funeral director C. S. Mumford

(b) Address New Franklin Mo

19. (a) 12-29-46 (b) Clay Morrow  
(Date received local registrar) (Registrar's signature)

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 J. T. Chamberlain (M. D. or other) \_\_\_\_\_  
Address New Franklin Mo Date signed 1-8-46

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

100110

7  
1  
2

1/17/46

71

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 2-7-46

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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 W. L. Hall  
Licensed Embalmer No. 3515  
P. O. Address New Franklin

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.

56-3-1