S. No. 2
M—5-42
. 5-17-39
P I X32873

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

4053

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED MAR 6 1946

STANDARD CERTIFICATE OF DEATH

State File No. 5048

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 12

1. PLACE OF DEATH:

(a) County COOPER

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

(c) Name of hospital or institution: 1310 MAIN ST 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 3 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County COOPER 27

(c) City or town BOONVILLE
(If outside city or town limits, write "RURAL") 2

(d) Street No. 1310 MAIN ST
(If rural, give location) 0

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

If yes, name country .....

3. (a) PRINT FULL NAME JAMES D. CAVE

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex MALE 0

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED 2

6. (b) Name of husband or wife MARTHA ANDERSON

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

7. Birth date of deceased NOVEMBER (Month) 25 (Day) - 1863 (Year)

8. AGE:

Years	Months	Days	If less than one day
82	2	8	..... hr. ..... min.

9. Birthplace SPRINGFIELD (City, town, or county) ILLINOIS (State or foreign country) 1

10. Usual occupation RETIRED FARMER

11. Industry or business RETIRED

FATHER
12. Name UNKNOWN 9
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name UNKNOWN 9
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant MRS C.R. SHY

(b) Address BOONVILLE, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/5/46 (Month) (Day) (Year)

(c) Place: burial or cremation IONIA, MO. CEM.

18. (a) Signature of funeral director STEGNER

(b) Address BOONVILLE, MO.

19. (a) 2/4/46 (Date received local registrar) (b) Clay Morris (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEBRUARY day 2nd year 1946 hour 9:30 minute a M.

21. I hereby certify that I attended the deceased from 2 Feb. 1946 to 4 Feb 1946 that I last saw him alive on ..... 19..... and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	a few minutes
Due to arteriosclerosis Cerebral	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy none

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 [signature] MD (M. D. or other)

Address Boonville Mo. Date signed 2.4.46

71 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 3,
District File Number
Date Filed 3-5-46

MAR 19 1948

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 W. Stegner

Licensed Embalmer No. 3780

P. O. Address Boonville, I

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.