DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 7 1948

Registration District No. 72

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29225

Primary Registration District No. 4289

Registrar's No. 95

1. PLACE OF DEATH:

(a) County CLAY Gallatin Twsp.

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

(c) Name of hospital or institution: HOME 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community II YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County CLAY 24

(c) City or town LINDEN, MO. 3
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

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

If yes, name country GERMANY

3. (a) PRINT FULL NAME ANNA MINNA NAVE

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex FEMALE 1

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 JULY (Month) 25 (Day) 1861 (Year)

8. AGE: Years 87 Months 1 Days 26 If less than one day hr. min.

9. Birthplace HOHENHAMELN, (City, town, or county) GERMANY 4 (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business

FATHER

12. Name JOHUNN HENRICH KONRAD NAVE

13. Birthplace (City, town, or county) GERMANY 4 (State or foreign country)

MOTHER

14. Maiden name KAROLINA SOPHIA GROTE

15. Birthplace (City, town, or county) GERMANY 4 (State or foreign country)

16. (a) Informant MISS ANNA KOENNEKER

(b) Address LINDEN, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/21/'48 (Month) (Day) (Year)

(c) Place: burial or cremation BARRY CEM. CLAY CO. MO.

18. (a) Signature of funeral director McCOMAS FUNERAL HOME

(b) Address SMITHVILLE, MO.

19. (a) Sept 21-48 (Date received local registrar) (b) Beulah Kitchen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 20 year 1948 hour 12:15 minute a.m.

21. I hereby certify that I attended the deceased from Jan 19 1946 to Sept 17 1948 that I last saw him alive on Sept 17 - 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis
Generalized Arteriosclerosis

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (City or town) (County) (State)

While at work? (Specify type of place) (e) Means of injury

23. Signature (M. D. or other) MD

Address Smithville Mo Date signed 9-21-48

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 10-6-48

NOV 22 1948

OCT 19 1956

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 S. A. McDonald,

Licensed Embalmer No. 2303

P. O. Address Smithville, Me

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.