

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

3514

27822

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Van Primary Registration District No. 120 St.
 City K.C. Mo. (No. 3237 East 10th St.) St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME

Elsie Edith Van Sandt
 (a) Residence. No. 3237 East 10th St., 12 Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF George Van Sandt

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 25 - 1906

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	22	9	20	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

10. NAME OF FATHER G.W. Spencer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Rodan Story

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

14. INFORMANT Geo. Van Sandt (Address) 3237-E-10th St.

15. FILED 8/16, 1929 M.M. Crowe asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 15, 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1929 to Aug 15, 1929 that I last saw her alive on Aug 15, 1929 and that death occurred, on the date stated above, at 11:50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute vegetative endocarditis (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) acute tonsillitis (Streptococci) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 109 B2

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS clinical & autopsy (Signed) Chas. Nelson M. D.

8-15, 1929 (Address) 1806 Fed Res Bk

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Clarksburg, Mo. DATE OF BURIAL Aug 15, 29

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K.C. Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

235

