

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

Do not use this space.

25742

1. PLACE OF DEATH

County *North*
Township *Witcham*
City *Grant City*

Registration District No. *903*
Primary Registration District No. *4575*

File No. _____
Registered No. *16*
St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred *35* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>m</i>	4. COLOR OR RACE <i>W</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF <i>Elizabeth Vanzant</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Feb. 26, 1858</i>		
7. AGE	YEARS <i>72</i>	MONTHS <i>4</i>
	DAYS <i>8</i>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>tinier</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>Self emp</i> (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Boff, Iowa</i>		
PARENTS	10. NAME OF FATHER <i>James Vanzant</i>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Boff, Iowa</i>	
	12. MAIDEN NAME OF MOTHER <i>Elizabeth Meeker</i>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Boff, Iowa</i>	
14. INFORMANT (Address) <i>Mrs Elizabeth Vanzant Grant City, Mo.</i>		
15. FILED <i>7/10/30</i> <i>John Currens</i> REGISTRAR		

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 4 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 3 1930* to *July 4 1930* that I last saw him alive on *July 4 1930*, and that death occurred, on the date stated above, at *3 P.M.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetes mellitus
59
137 (duration) yrs. *12* mos. - ds.

CONTRIBUTORY (SECONDARY) *Infection of prostate gland.* (duration) yrs. *6* mos. - ds.

WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? *No.* DATE OF _____

WAS THERE AN AUTOPSY? *No.*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *J. Phipps* M. D.
Grant City, Mo.

*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 <i>Grant City, Com.</i>	DATE OF BURIAL <i>7/6 1930</i>
20. UNDERTAKER <i>Arch C. Duffee</i>	ADDRESS <i>Grant City</i>

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

MARCA RESERVED FOR BIR

V. S. No. 2.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE AND CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important.

