

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

Do not use this space.

25860

1. PLACE OF DEATH

County Bollinger
Township Liberty
City Adalene Vandover (No. _____)

Registration District No. 67
Primary Registration District No. 1104

File No. _____
Registered No. 22
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 4 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) Infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 23-1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
7 7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
(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) Near Leopolis Mo.

10. NAME OF FATHER John Vandover

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Bollinger Co.

12. MAIDEN NAME OF MOTHER Josephine Phelps

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Bollinger Co.

14. INFORMANT John Vandover
(Address) Leopolis, Mo.

15. FILED SEP 21 1930 W. A. Sander REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 29 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1930, to Aug 29, 1930 that I last saw him alive on Aug 29, 1930, and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cholera Infantum
119A

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) Good condition of bowels from milk
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Place of death
DID AN OPERATION PRECEDE DEATH? Yes DATE OF _____
WAS THERE AN AUTOPSY? Physical Examination
WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) M. J. Finney M. D.
19 (Address) Leopolis 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 Leopolis Cemetery DATE OF BURIAL Aug 31 1930

20. UNDERTAKER G. Anger ADDRESS Leopolis

