

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

Do not use this space.

37238

File No. _____
Registered No. 228
St. _____ Ward _____

1. PLACE OF DEATH
County St. Louis Registration District No. 785
Township Bonhomme Primary Registration District No. 6031
City _____ (No. _____)

2. FULL NAME William Vance
(a) Residence. No. Chesterfield, Mo St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. 4 mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widower</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Unknown</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov-20-1859</u>		
7. AGE	YEARS <u>70</u>	MONTHS <u>9</u>
	DAYS <u>25</u>	If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Log Contractor</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Log</u> (c) Name of employer <u>Missouri Lumber Co. Mo</u>		

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

PARENTS	10. NAME OF FATHER <u>John Vance</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Unknown</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Unknown</u>

14. INFORMANT D. C. Kroening
(Address) Chesterfield, Mo

15. FILED 12/9 1930 P. E. Barneitz
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov-15-1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1930, to Nov 15 1930, that I last saw him alive on Nov 15 1930, and that death occurred, on the date stated above, at 7:45 - P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterio-Sclerosis
Uremia Poisoning, decomp
970 (duration) yrs. 4 mos. _____ ds.
CONTRIBUTORY Uremia and decomp
(SECONDARY) (duration) yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) Robert Terry M. D.

11-16 1930 (Address) Chesterfield 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 <u>Lumbo Cem - Lumbo Mo</u>	DATE OF BURIAL <u>Nov-17 1930</u>
20. UNDERTAKER <u>Schrader Hud Co</u>	ADDRESS <u>Bullrun Mo</u>

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

DEC 23 1930
N. B.—Every item of information 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.

U. S. No. 2.

29 38-45
19 30 11 20
18 5-9
---70-9-25