

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

Do not use this space.

18613

*Rained*

1. PLACE OF DEATH  
 County *Macon* Registration District No. *529*  
 Township *Morrow* Primary Registration District No. *5706*  
 City (No. ) St. Ward

2. FULL NAME *Robert O. Vauskike*  
 (a) Residence No. St. Ward.  
 (Usual place of abode)  
 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 *Male* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 22" 1847*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*84 - 15*

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Retired*  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Macon Mo. 1*

MOTHER FATHER  
 13. NAME *Robert Vauskike*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Pa. 2*  
 15. MAIDEN NAME *Pollyann Valley*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky*

17. INFORMANT (ADDRESS) *William Vauskike  
Callao Mo. R.F.D.*

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE *Friendship* DATE *5-9" 1931*

19. UNDERTAKER (ADDRESS) *Stephen J. Gooding  
Macon Mo*

20. FILED 19 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5-7-1931*

22. I HEREBY CERTIFY, That I attended deceased from *May 7*, 19*31*, to *5-7*, 19*31*  
 I last saw him alive on *5-7*, 19*31*. Death is said to have occurred on the date stated above, at *4:00* p.m.  
 The principal cause of death and related causes of importance were as follows:  
*Stenocardia*  
*107*  
 Other contributory causes of importance:  
 Name of operation Date of  
 What test confirmed diagnosis? Was there an autopsy?  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Date of injury, 19  
 Where did injury occur? (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury Nature of injury  
 24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify  
 (Signed) *J. W. ...*, M. D.  
 (Address) *...*

JUN 27 1931

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.  
 County Macon Registration District No. 3-2-9-24 File No. \_\_\_\_\_  
 Township Morrow Primary Registration District No. 3-706 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Robert O. Vanshike  
 (a) Residence. No. \_\_\_\_\_ 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. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 22 1847

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
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8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Retired  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Macon Mo  
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Robert Vanshike

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Pa.  
 (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Polly Ann Halley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky.  
 (STATE OR COUNTRY) \_\_\_\_\_

PARENTS

14. INFORMANT William Vanshike  
 (Address) Callao mo R.F.D.

15. FILED July 5 1931 F.L. Trippeer, M.D.  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 7 1931

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_, (that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pneumonia  
Broncho

CONTRIBUTORY (SECONDARY) 1070  
 (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) A.M. Raines, M. D.  
 , 19 (Address) Macon 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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 19\_\_\_\_

20. UNDERTAKER Stephus & Goldberg ADDRESS \_\_\_\_\_

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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