LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

JAN 4 1934

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

38775

1. PLACE OF DEATH
County Schuyler — Registration District No. 804 — File No.
Township Salt River — Primary Registration District No. 6049 — Registered No.
City Greentop (No. ..... St. ..... Ward)

2. FULL NAME Cinderella Vanwey
(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: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 18th 1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
83		10	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ohio
(STATE OR COUNTRY) Washington Co.

PARENTS
10. NAME OF FATHER Joseph Vanwey
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Sarah Lenington
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

14. INFORMANT John Vanwey
(Address) Greentop Mo.

15. FILED Nov. 6-1933 Mrs O P Farrington
REGISTRAR

2 **MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH, (MONTH, DAY AND YEAR) Nov 5 1933

17. I HEREBY CERTIFY, That I attended deceased from Sept 30, 1933, to To Oct 30, 1933 that I last saw her alive on Oct 30, 1933, and that death occurred, on the date stated above, at 6 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Organic Heart disease
95B
162 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Infirmities Age
(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) O P Farrington, M. D.
, 19 (Address) Green Top 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: Greentop — DATE OF BURIAL: Nov 6, 1933

20. UNDERTAKER: L. O. Young — ADDRESS: Greentop

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

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.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No....., ...St. .....Ward)

2. FULL NAME.....

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

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

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT.....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from.....
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
..... (duration) .....yrs.....mos.....ds.

CONTRIBUTORY.....
(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)..... ....., M. D.

, 19 (Address)

*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	ADDRESS

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

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