

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.

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

Do not use this space.

1935 8 8 1935

4191

1. PLACE OF DEATH

County St. Louis
Township St. Charles
City Grant City (No.)

Registration District No. 903
Primary Registration District No. 4543

File No.
Registered No.
St. Ward)

2. FULL NAME

Dwight Bruce Vanhooser

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

Length of residence in city or town where death occurred yrs. 11 mos. 8 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 m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (with the word) Child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 23, 1924

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
11 8

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. child

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

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) Grant City Mo.

FATHER 13. NAME Leslie Vanhooser

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Martinsville Mo.

MOTHER 15. MAIDEN NAME Leone Philpino

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Albany Mo.

17. INFORMANT (ADDRESS) Leslie Vanhooser Grant City Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Grant City Mo. DATE 1/13 1935

19. UNDERTAKER (ADDRESS) Arch C. Dungee

20. FILED Jan 9, 1935 Fred Hull Mo. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 1 1935

22. I HEREBY CERTIFY, That I attended deceased from Dec 26, 1934, to Jan 1, 1935

I last saw him alive on Jan 1, 1935. Death is said to have occurred on the date stated above, at 8:30 p.m.

The principal cause of death and related causes of importance were as follows:
Brachial Pneumonia

Other contributory causes of importance: 10/1/35

Name of operation Physician's Date of 1/1/35
What test confirmed diagnosis? Physician's Was there an autopsy? No

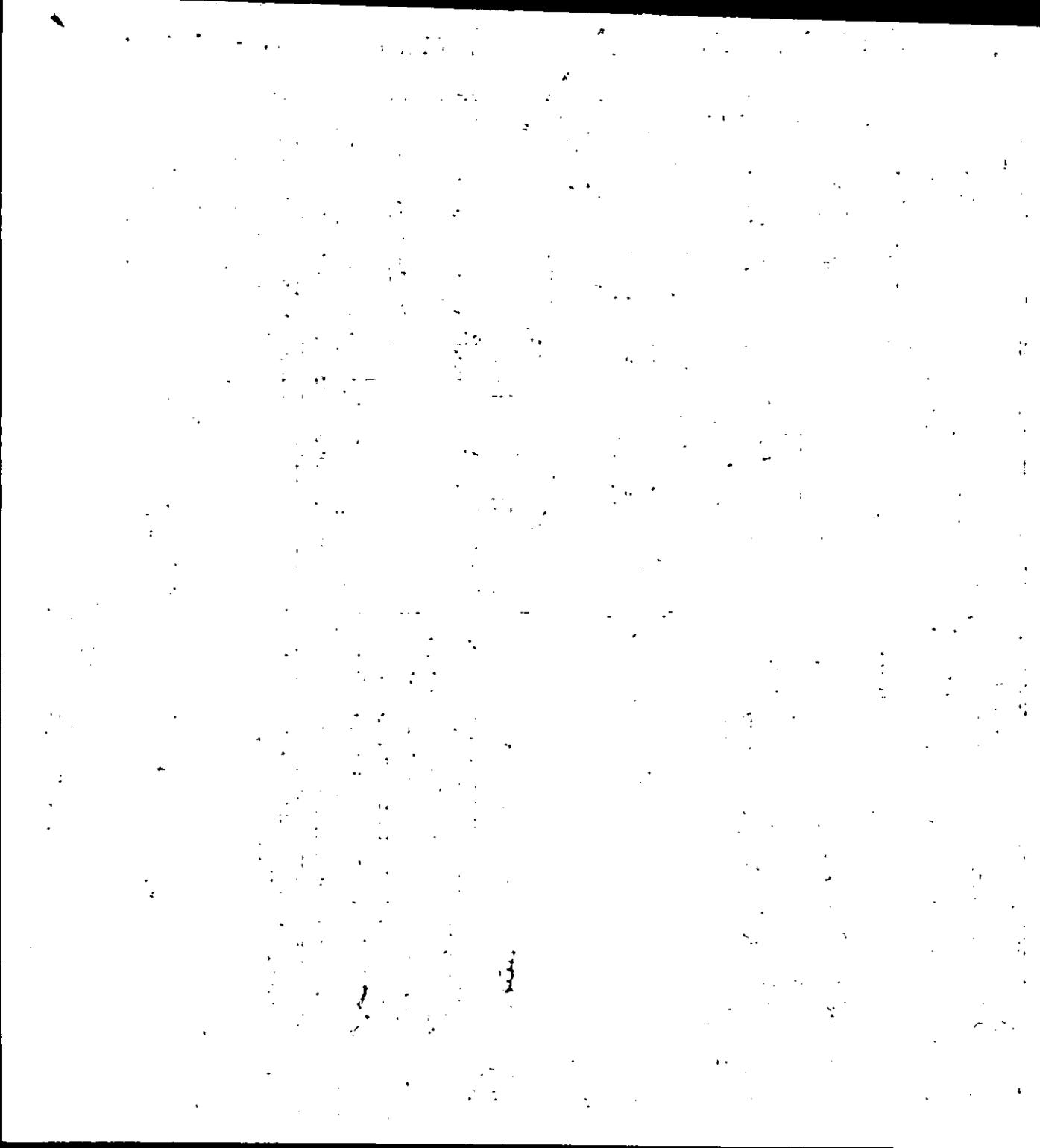
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Yes Date of injury 1/1/35
Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Y
Nature of injury Y

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Fred Hull, M. D.
(Address) Grant City Mo.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County North
Township.....
City..... (No. St. Ward)

Registration District No. 903-
Primary Registration District No. 4545-

File No. 4191-
Registered No.

2. FULL NAME

Dudley P. Vanhoyzer
(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 8- (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. 11 8-

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.

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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 6-28-1935 J. Redmill

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 1, 1935

22. I HEREBY CERTIFY, That I attended deceased from to 19.....
I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:
Bronchial Pneumonia (Date of onset)

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? 17

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) O. G. Ross, M. D.
(Address)

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. None should be stated EXACTLY. PHYSICIANS should state

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