

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.

44951

1. PLACE OF DEATH

County Jackson  
Township Kaw  
City Kansas City (No. 5416)

Registration District No. 399  
Primary Registration District No. 1002

File No. 6299  
Registered No. 553  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Mrs. Annie Vancil

(a) Residence, No. 5416 Wabash 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 17/8 76

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
60 8 6

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None  
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) Missouri

MOTHER FATHER 13. NAME William B. Colyer

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

15. MAIDEN NAME Clara E. Gilliland

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

17. INFORMANT Mrs. Myrna Thorn (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE 5416 Wabash Cape Girardeau Mo. DATE Dec 25 1936

19. UNDERTAKER D. W. Newcomer's Sons (ADDRESS) Brushcreek & Paseo

20. FILED Dec 26 1936 M. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/23/36 19

22. I HEREBY CERTIFY, That I attended deceased from 9/15/36, 19, to 12/23/36, 19.

I last saw him live on 12/23/36 19. Death is said to have occurred on the date stated above, at 1:40 p.m.

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

Carcinoma of uterus

Date of onset

9/15/36

Other contributory causes of importance: none

Name of operation no Date of \_\_\_\_\_

What test confirmed diagnosis? biopsy Was there an autopsy? no

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? no

If so, specify \_\_\_\_\_

(Signed) Joseph M. Brown, M. D.

(Address) 925 W. 11th St.

