

OCT 20 1937

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

Do not use this space.

## 1. PLACE OF DEATH

County HarrisonTownship Bethany

City

(No. \_\_\_\_\_)

Registration District No. 1012Primary Registration District No. 3480File No. 34331Registered No. 2

St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Callie Vance

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M.5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Chas. Vance6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-16-18717. AGE YEARS 66 MONTHS 0 DAYS 22 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife  
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 occupation12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clay Co. Mo.13. NAME Benjamin Clark14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky15. MAIDEN NAME Mathie Arnold16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clay Co. Mo.17. INFORMANT (ADDRESS) Chas. Vance  
Bethany Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Mathins DATE 10/10 193719. UNDERTAKER (ADDRESS) L. M. Hays  
Bethany, Mo.20. FILED Oct 10 1937 M. W. Wood & Son Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/8 193722. I HEREBY CERTIFY, That I attended deceased from July 1937, to October 1937I last saw h. & R. alive on 10-8-37, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 6:20 p. m.

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

Myocardial failure Date of onset 1934  
Cerebral thrombosis 1935Other contributory causes of importance: 15  
Kidney impairment 1935Name of operation none 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? No.

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

(Signed) Eugene D. Neville, M. D.(Address) Bethany, Mo.

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.



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

34331  
Do not use this space.

1. PLACE OF DEATH

(a) County Harrison Registration District No. 1012  
(b) Township Butler Primary Registration District No. 5480 Registered No. 2  
(c) City..... (d) Street No.....  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Callie Vance

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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.  
60 0 22

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 11-23-37 afternoon Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/8 1937

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ 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:

myocardial failure  
cardiac decompensation  
10  
Date of onset

Other contributory causes of importance:  
kidney impairment  
chronic glomerular nephritis

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) Eugene D. Neville, M. D.

(Address) Bethany

SUPPLEMENTARY

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

