

CPD OCT 25 1938

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

32934
Do not use this space.

1. PLACE OF DEATH

(a) County Osage County Registration District No. 641
(b) Township Sackson Primary Registration District No. 5850
(c) City Meta Mo (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 74 yrs. 3 mos. 24 ds. (f) How long in U. S., if of foreign birth? _____ yrs. mos. ds.

Registered No. 12

2. PRINT FULL NAME

John Henry Wansing
(a) Residence, No. Meta Mo St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 31, 1864
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 3 24
8. Trade, profession, or particular kind of work done, as Sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. Own Farm
10. Date deceased last worked at this occupation (month and year) 10 yrs ago 11. Total time (years) spent in this occupation 40 yrs

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Meta Mo O
13. NAME John Wansing 6
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 6
15. MAIDEN NAME Katherine Lueckenotto
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Elizabeth M Wansing
Meta Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Celia Cem DATE 9-27 1938
19. FUNERAL DIRECTOR (ADDRESS) H.H. Stroup
Meta Mo
20. FILED Sept 26 1938 Robert Prater
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _____, 19____
22. I HEREBY CERTIFY, That I attended deceased from 8-2-38, 19____, to 9-24, 1938
I last saw h. m. alive on 9-24, 1938 Death is said to have occurred on the date stated above, at 6:20 a.m.
The principal cause of death and related causes of importance were as follows:

Broncho Pneumonia
Myocardial Degeneration
191
Other contributory causes of importance:
Hemiplegia (left)
Chronic Nephritis
Arterio Sclerosis

Date of onset 9-18-38
?
?
?

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ 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? _____
If so, specify _____
(Signed) Leon A Taylor, M. D.
572 (Address) Meta Mo

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STATEMENT BY LICENSED EMBALMER

I, Herman H Strop, Licensed Embalmer No. 29
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Herman H Strop
L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Herman H Strop
Licensed Embalmer No. 29

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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32934
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1. PLACE OF DEATH

(a) County Osage Registration District No. 641
(b) Township Jackson Primary Registration District No. 5830 Registered No. _____
(c) City _____ (d) Street No. _____ St.
(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.

PRINT FULL NAME

(a) Residence, No. John Henry Wansing 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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.
74 3 24

OCCUPATION 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

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Aug 26 1938 Robert Crater Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 24 1938

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:

Date of onset

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) Leon A Taylor, M. D.

(Address) Moete mo

SUPPLEMENTAL

