

REC'D AUG 22 1939

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

26999
Do not use this space.

1. PLACE OF DEATH

(a) County Shannon Registration District No. 8-3
 (b) Township Arnold Primary Registration District No. 6074
 (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.

2. PRINT FULL NAME

(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 M 4. COLOR OR RACE A 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) May 15 - 1938

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
14 15

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) Mo

FATHER 13. NAME Rhoda David Vanvulle

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

MOTHER 15. MAIDEN NAME Rhoda Bradshaw

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

17. INFORMANT (ADDRESS) Mary Taylor
Arnold Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Not known DATE 7-29-39

19. FUNERAL DIRECTOR (NAME) none (ADDRESS) _____

20. FILED 7-29-39

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 28 - 1939

22. I HEREBY CERTIFY, That I attended deceased from July 23, 1939, to July 29, 1939.
 Last saw him alive on July 27, 1939. Death is said to have occurred on the date stated above, at 6 P m.
 The principal cause of death and related causes of importance were as follows:

Gastro Enteritis

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 _____, 1939
 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 Frank Seale, M. D.

(Signed) Seale Address Seale's no

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

Signed.....

District File Number 839106

Licensed Embalmer No.....

Date Filed 8/4/39

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

26999

Do not use this space.

1. PLACE OF DEATH

(a) County Shannon Registration District No. 1 823
(b) Township Winston Primary Registration District No. 5074 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.

2. PRINT FULL NAME Elmer Jones Van Winkle

(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 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) 5-15-1938

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
14 15

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) MO

FATHER 13. NAME David Van Winkle

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

MOTHER 15. MAIDEN NAME Rhoda Berkshire

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

17. INFORMANT (ADDRESS) Margaret Douglas Winston

18. BURIAL, CREMATION, OR REMOVAL PLACE Mid Zion DATE 7-29

19. FUNERAL DIRECTOR (ADDRESS) none

20. FILED 7-29 1939 Frank Hyde MD Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 28 1939

22. I HEREBY CERTIFY that I attended deceased from July 25 to July 28, 1939.
I last saw him alive on July 29, 1939. Death is said to have occurred on the date stated above, at 6 p. m.

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

Gastric Enteritis 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) Frank Hyde, M. D.

(Address) Winston

S-26999

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