

FILED MAR 11 1940

Registration District No. 399Primary Registration District No. 1002Registrar's No. 655

1. PLACE OF DEATH:

- (a) County Jackson
 (b) City or town J.C. Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Mem Hosp - 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days
 (Specify whether

In this community 2 years
years, months or days3. (a) PRINT
FULL NAMERobert Lewis Vance3. (b) If veteran,
name war 3. (c) Social Security
No. ✓4. Sex M
5. Color or
race W6. (a) Single, widowed, married,
divorced Child6. (b) Name of husband or wife ✓6. (c) Age of husband or wife if
alive ✓ years7. Birth date of deceased Oct - 5 - 1934
(Month) (Day) (Year)8. AGE: Years 5 Months 3 Days 6
If less than one day
hr. min.9. Birthplace Camolton Mo
(City, town, or county) (State or foreign country)10. Usual occupation Child11. Industry or business Child12. Name Robert M. Vance13. Birthplace Colona Mo
(City, town, or county) (State or foreign country)14. Maiden name Sylvia Kumpsheld15. Birthplace Bogard Mo
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Sylvia Vance(b) Address 1225 Cedar Mill Mo17. (a) Burial (b) Date thereof Feb - 13 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mo18. (a) Signature of funeral director Robert Henderson(b) Address 1600 Professional Bldg19. (a) Feb. 12, 1940 (b) M. M. Crane
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Jackson
 (c) City or town 0 (If outside city or town limits, write "RURAL")
 (d) Street No. 1225 Cedar Mill Mo (If rural, give location)
 (e) If foreign born, how long in U. S. A.? Life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 11
year 1940 hour 2 minute 2 A. M.21. I hereby certify that I attended the deceased from Feb. 7, 40 to
Feb. 11, 1940,
that I last saw him alive on Feb. 10, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Acute Osteomyelitis
Rt. Femur Duration 1 day
154Due to Staphylococcus Albus Septicemia

Due to _____

Other conditions Metastatic Abscesses
(Include pregnancy within 3 months of death)Major findings: Access mid 1/3 FemurOf autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury ✓23. Signature James P. Reider (M. D. or other) _____Address 1600 PROFESSIONAL BLDG Date signed 2-12-40

Duration

1 day

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically.

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.....

Van Laura (Apprentice) Registered Apprentice No.
working under my personal supervision..

Signed *John B. Day*

Licensed Embalmer No. *295-5*

P. O. Address *K.C. Mo*

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

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