DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 8300

Registration District No. [illegible] MAR 14 1940 Primary Registration District No. 4589 Registrar's No.

**1. PLACE OF DEATH:**

(a) County Scott

(b) City or town Vanduser (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Scott

(c) City or town Vanduser (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Infant of Delois Greer

3. (b) If veteran, name war Infant

3. (c) Social Security No. Infant

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced infant

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased February (Month) 21 (Day) 1940 (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 4 hr. 45 min.

9. Birthplace Vanduser (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Delois Greer
13. Birthplace East St. Louis (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Velma Waltrip
15. Birthplace Clarkton (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Delois Greer

(b) Address Vanduser, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (Month) 22 (Day) 40 (Year)

(c) Place: burial or cremation McMullin Missouri

18. (a) Signature of funeral director Harvey [illegible]

(b) Address [illegible]

19. (a) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month February day 22nd year 1940 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb. 21, 1940, to Feb 21, 1940 that I last saw him alive on Feb 21, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure or Non compensating heart

Due to Very much hypertrophy at limits

Due to Nat. [illegible]

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address [illegible] Date signed 2-22-40

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

50M-5-17-39 Rev. 5-17-39 I X19511

RECEIVED
District Health Officer No. 2,
340 - 13
District File No. 3/11/40
District Health Officer No. 2

RECEIVED

**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 Body not Embalmed, Registered Apprentice No. ....., working under my personal supervision.

Signed Harvey S Johnson

Licensed Embalmer No. 3704

P. O. Address Sikeston 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.**

S. No. 2B
1—2-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 8300

Registration District No. 819 Primary Registration District No. 4589 Registrar's No.

1. PLACE OF DEATH
(a) County Scott
(b) City or town Vanduser
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Infant C. Delois Green
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day 4 hr. 43 min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) April-15-1940 (Date received local registrar) (b) Mrs L Daugherty (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature H. A. Mayfield (M. D. or other)
Address Sikeston Mo Date signed

SUPPLEMENTARY