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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31247

OCT 23 1940

Registration District No. 1 — Primary Registration District No. 1 — Registrar's No. 228

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

1. PLACE OF DEATH:

1 (a) County Adair

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

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

(d) Length of stay: In hospital or institution 1 hour (Specify whether years, months or days) 1

In this community 1 hour

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan

(c) City or town Humphrey — rural (If outside city or town limits, write "RURAL")

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

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

3. (a) PRINT FULL NAME Viva Ruth Van Fossen

3. (b) If veteran, name war ✓ — 3. (c) Social Security No. ✓

4. Sex F — 5. Color or race W — 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ✓ — 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased Sept. (Month) 28 (Day) 1940 (Year)

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

9. Birthplace Humphrey (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Newborn 0

11. Industry or business X 0

FATHER
12. Name Kirby Van Fossen
13. Birthplace Humphrey (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Vibran Ramey
15. Birthplace Humphrey (City, town, or county) Mo (State or foreign country)

16. (a) Informant Mr Kirby Van Fossen
(b) Address Humphrey, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 40 (Month) (Day) (Year)
(c) Place: burial or cremation Humphrey Mo.

18. (a) Signature of funeral director P. Payne Toon
(b) Address Galt Mo

19. (a) Oct. 3/40 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 1 year 1940 hour 9 minute P M.

21. I hereby certify that I attended the deceased from 10-1, 1940, to 10-1, 1940, that I last saw her alive on 10-1, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Congenital absence of anus	4 days
Atelactasis	4 days
~~Due to~~ Jaundice newborn (gravis)	4 days
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

157 D

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)
3 While at work? (e) Means of injury

23. Signature J. Kimp M.D. (M. D. or other) 1
Address Kirksville Date signed 10-1-40

(Licensed Embalmer's Statement on Reverse Side)

Spencer Freeman
F.R.

RECEIVED
District Health Officer No. 10
District File Number 60-40-2006
Date Filed OCT 24 1940

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.

Signed .....

Licensed Embalmer No. .....

P. O. Address .....

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

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