

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.

FILED NOV 25 1940

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

36553  
Do not use this space.

1. PLACE OF DEATH 20  
(a) County Stoddard Registration District No. 840  
(b) Township Buck Creek Primary Registration District No. 6102 Registered No. 33  
(c) City Osborneville 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, 3 yrs. 11 mos. 7 da. (f) How long in U. S., if of foreign birth? 44 yrs. 9 mos. 21 ds.

2. PRINT FULL NAME CHARLEY FRANKLIN Vansinger  
(a) Residence, No. \_\_\_\_\_ St. Vansyoe  
(Usual place of abode, if no street address, write county or city) \_\_\_\_\_ (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-14-1895  
7. AGE YEARS 44 MONTHS 9 DAYS 22 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
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. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) Farmer 11. Total time (years) spent in this occupation. \_\_\_\_\_  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 2nd Field Jlt-1 (Vansyoe)  
13. NAME William Vansyoe  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 2nd  
15. MAIDEN NAME Sarah Madalyn  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jlt.  
17. INFORMANT Bob Van Sycor  
(ADDRESS)  
18. BURIAL, CREMATION, OR REMOVAL PLACE Plained Home DATE 10-7 : 1940  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Matthew Funeral Home  
Springer mo.  
20. FILED Oct. 8 1940 Be Maria Dupont Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 6 1940  
22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
I last saw him alive on Aug 1, 1940. Death is said to have occurred on the date stated above, at 4:30 P.M.  
The principal cause of death and related causes of importance were as follows:  
Pulmonary Tuberculosis  
Date of onset about 10-2 yrs ago  
Other contributory causes of importance: None  
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? no  
(Signed) E. R. Edmund, M. D.  
(Address) Osborneville mo

RECEIVED

District Health Officer No. 2,

District File Number 1140-167

Date Filed 11/7/40

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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, .....

Virgil H. Kelch ....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed Virgil H. Kelch .....

Licensed Embalmer No. 4102

P. O. Address Dexter, 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **36553**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **840**

Primary Registration District No. **6102**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Stoddard**  
(b) City or town **Duck Creek**  
(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.....

In this community..... (Specify whether years, months or days) **12**

3. (a) PRINT FULL NAME

**Charley Franklin Dansey**

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 **wid**

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 **44** Months **9** Days **22** If less than one day, hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name..... (City, town, or county) (State or foreign country)

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) **10-8-1940** (b) **Dennis Dupont** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Stoddard**

(c) City or town **Copico** (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **6** 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.....

Due to.....

Due to.....

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?

While at work?..... (Specify type of place) (c) Means of injury.....

23. Signature **E. L. Elmore** (M. D. or other).....

Address **Copico Mo** Date signed.....

SUPPLEMENTAL