

Registration District No.

124

Primary Registration District No.

4070

Registrar's No.

41

1. PLACE OF DEATH:

- (a) County CAPE GIRARDEAU
- (b) City or town JACKSON MO
(If outside city or town limits, write "RURAL" and name of town)
- (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 2
(Specify whether years, months or days)

In this community
years, months or days3. (a) PRINT
FULL NAMERuth Ann Vangilder3. (b) If veteran,
name war3. (c) Social Security
No. four4. Sex F5. Color or
race W6. (a) Single, widowed, married,
divorced S

6. (b) Name of husband or wife

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

7. Birth date of deceased

March
(Month)11
(Day)1940
(Year)

8. AGE:

Years

Months

Days

If less than one day

83

hr. _____ min.

9. Birthplace

Jackson

(City, town, or county)

MO.

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name Ed Vangilder13. Birthplace CAPE GIRARDEAU

(City, town, or county)

MO

(State or foreign country)

14. Maiden name Grace Johnson15. Birthplace Jackson

(City, town, or county)

MO

(State or foreign country)

16. (a) Informant's own signature

Ed Vangilder

(b) Address

Jackson MO17. (a) BURIAL
(Burial, cremation, or removal)

(b) Date thereof

11-16-40
(Month) (Day) (Year)

(c) Place: burial or cremation

RUSSELL HEIGHTS

18. (a) Signature of funeral director

Wacke Wilson Staller

(b) Address

Jackson MO19. (a) 11/17-40
(Date received local registrar)

(b)

D. S. Secher
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County CAPE GIRARDEAU
- (c) City or town Jackson
(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 November day 15th
year 1940 hour 2:00 minute 30 A. M.21. I hereby certify that I attended the deceased from Nov. 15, 1940
_____, 19____, to Same date, 19____;
that I last saw her alive on November 15th, 19____;
and that death occurred on the date and hour stated above.Immediate cause of death CompleteDue to Consolidation of
both lungs
Bacterial pneumonia

Duration

14 weeks

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 sta-
tistically.

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?
120

23. Signature R. P. Tindal
While at work _____ (Specify type of place)
(e) Means of injury _____
Address Jackson MO Date signed 11/14/40

1072

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.....

Glenn Wilson

Registered Apprentice No. *2338*

working under my personal supervision.

Signed.....

Glenn Wilson

Licensed Embalmer No. *2828*

P. O. Address *Jaerson 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.

No. 2B
2-21-40
I X 12

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38351

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 124

Primary Registration District No. 4070

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(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 _____ (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

Ruth Ann Vaugilder

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 S

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
8 3 _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov day 15
year _____ 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 Complete consolidation of both lungs.

Due to Whooping Cough prior
Bronchial Pneumonia

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) (Means of injury)

23. Signature Dr. Albert Lindell (M. D. or other) _____
Address Jackson, Mo. Date signed 1/29/51

SUPPLEMENTAL

