

No. 2  
-2-43  
5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 19 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8550

State File No. ....

Registration District No. 341

Primary Registration District No. 3075

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Dexter  
(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 Stoddard <sup>103</sup>

(c) City or town Dexter <sup>3</sup>  
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ <sup>0</sup>

3. (a) PRINT FULL NAME Simpson Grant Wantland

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lottie Wantland 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Jan 14 1865  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

79	0	27	hr. _____ min.
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9. Birthplace Green Castle Ind. (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name Joseph Wantland

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

14. Maiden name Miriam Shaw

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

16. (a) Informant Mrs. Lottie Wantland

(b) Address Dexter, Mo.

17. (a) burial (b) Date thereof 2-15-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dexter Cemetery

18. (a) Signature of funeral director Blankenship-Strickland

(b) Address Dexter, Mo.

19. (a) 3-1-1944 (b) Nora Smith  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 11 year 1944 hour 8 minute 15 A. M.

21. I hereby certify that I attended the deceased from Feb. 5, 1944 to Feb. 11, 1944

that I last saw him alive on 2-11-1944 and that death occurred on the date and hour stated above.

Immediate cause of death Double Lobar Pneumonia Duration 6 Day

Due to Cerebral hemorrhage Feb. 1st 1944. Artero-sclerosis

Due to Hypertension

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy no

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

(a) Accident, suicide, or homicide (specify) no

(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 0

23. Signature S. S. Davis (M. D. or other) \_\_\_\_\_

Address Dexter Date signed 2/15/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

03  
13

1134

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No.

District File Number 344-44

Date Filed 3-9-44

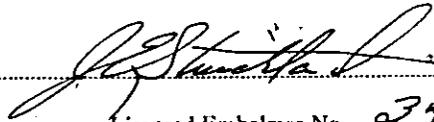
STATEMENT BY LICENSED EMBALMER

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. 3479

P. O. Address Weymouth, Mass.

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, fact should be so stated above.