

FILED JUL 24 1944

Registration District No. **160**

Primary Registration District No. **3-0-3-0-0592**

Registrar's No. **111**

1. PLACE OF DEATH  
 (a) County **Jefferson**  
 (b) City or town **Rural Joachims**  
 (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) **1**  
 (d) Length of stay: In hospital or institution. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **Jefferson**  
 (c) City or town **Rural** **50**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **R R #2** **0**  
 (If rural, give location) **0**  
 (e) Citizen of foreign country? (Yes or No) **0**  
 If yes, name country.

3. (a) PRINT FULL NAME **William H. Vincent**  
 (b) If veteran, name war  
 (c) Social Security No.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **3rd** day **31st**  
 year **1944** hour **4** minute **0 P.** M.  
 21. I hereby certify that I attended the deceased from **Mar 21-1944**  
**one week**, 19 to **April 1**, 19 **44**  
 that I last saw h. alive on **Mar 21**, 19 **44**  
 and that death occurred on the date and hour stated above.

4. Sex **M**  
 5. Color or race **W**  
 6. (a) Single, widowed, married, divorced **married**  
 (b) Name of husband or wife **Elizabeth Ann Vincent**  
 6. (c) Age of husband or wife if alive, years **31**  
 7. Birth date of deceased **Aug 1870**  
 (Month) (Day) (Year)

Immediate cause of death **Chronic myocarditis**  
 Duration  
 Due to **930**  
 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.

8. AGE: Years **73** Months **7** Days **0**  
 If less than one day hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business

MOTHER FATHER

12. Name **Elyz Vincent**  
 13. Birthplace **Unknown**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **Martha Schneider**  
 15. Birthplace **Unknown**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **Dave Vincent**  
 (b) Address **Bloomsdale Mo**

17. (a) **Burial** (b) Date thereof **4-2-44**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Concord Cem. (Chgo)**

18. (a) Signature of funeral director **Fink Funeral Parlor**  
 (b) Address **Fertus Mo.**

19. (a) **4-1-44** (b) **Mrs. Lilly Williams**  
 (Date received local registrar) (Registrar's signature)

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?  
 (e) Means of injury  
 23. Signed **O. J. Vassio MD** (M. D. or other)  
 Address **Fertus** Date signed **4/2/44**

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

50000

RECEIVED

District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed 7-21-44

**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 Elean Province

Licensed Embalmer No. 3403

P. O. Address Jestus M

**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.