

No. 2
-8-13
17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27447**
Registrar's No. **33**

FILED SEP 8 1944

Registration District No. **254** Primary Registration District No. **3074**

1. PLACE OF DEATH:

(a) County **Cape Girardeau**
(b) City or town **JACKSON**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(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 **Mo** (b) County **Cape Gir. 16**
(c) City or town **JACKSON** (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 _____

3. (a) PRINT FULL NAME **John William VanAmburg**

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

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **1**
6. (b) Name of husband or wife **Joanna Wood** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **July 17 1885**
(Month) (Day) (Year)

8. AGE: Years **79** Months **1** Days **12** If less than one day hr. _____ min. _____

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

10. Usual occupation **Timber Inspector**

11. Industry or business _____

MOTHER FATHER

12. Name **John VanAmburg**
13. Birthplace **Missouri** (City, town, or county) _____ (State or foreign country)
14. Maiden name **Amanda Sisson**
15. Birthplace **Cape Gir. Co.** (City, town, or county) _____ (State or foreign country)

16. (a) Informant **Mrs. Frank James**
(b) Address **Cape Girardeau**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **8-31-1944** (Month) (Day) (Year)
(c) Place: burial or cremation **JACKSON, MO.**

18. (a) Signature of funeral director **J. C. ...**
(b) Address **908 ...**

19. (a) **1944** (Date received local registrar) (b) **J. H. ...** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **29** year **1944** hour **7** minute **2** A.M.

21. I hereby certify that I attended the deceased from **Aug 22**, 19**44** to **Aug 29**, 19**44**.
that I last saw him alive on **Aug 28**, 19**44** and that death occurred on the date and hour stated above.

Immediate cause of death **Apoplexy** Duration **7 day**
Due to _____
Due to **Stroke**

Other conditions **Paralysis Left arm** 7 day
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
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) (e) Means of injury _____
23. Signature **J. H. ...** (M. D. or other) _____
Address **JACKSON MO** Date signed **8-29-44**

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

RECEIVED

District Health Officer No. 4
District File Number 944-4308
Date Filed 9-7-44

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 Thos. E. Allen

Licensed Embalmer No. 40555

P. O. Address Wicklow

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Cape Girardeau
 (b) City or town Jackson
(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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME John W. Van Amburg
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH, Month Aug Day 29
 year 1944 hour _____ minute _____ M. _____
 21. I hereby certify that I attended the deceased from _____ 19____; _____ 19____;
 that I last saw h _____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

7. Birth date of deceased July 17 (Month) (Day) (Year)
 8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.
 9. Birthplace New Baltimore Mo (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 _____
 15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____
 17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
 (c) Place: burial or cremation _____
 18. (a) Signature of funeral director McLouth Funeral Home
 (b) Address Jackson 700
 19. (a) 8/30 (b) J. H. Heubner
(Date received local registrar) (Registrar's signature)

Due to _____
 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.
 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)
 (e) Means of injury _____
 23. Signature _____ (M. D. or other)
 Address _____ Date signed _____

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

SUPPLEMENTARY

27447