S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 9 1945

Registration District No.

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16202

Primary Registration District No. 3002

Registrar's No. 75

1. PLACE OF DEATH:
(a) County Audrain
(b) City or town Mexico
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 619 E. Promenade St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 3 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Ind. (b) County
(c) City or town Princeton
(If outside city or town limits, write "RURAL")
(d) Street No. 505 Seminary St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary Ellen Vandeveer
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Louis B. Vandeveer
6. (c) Age of husband or wife if alive years
7. Birth date of deceased October 28, 1868 (Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days 17 If less than one day hr. min.

9. Birthplace Gibson County, Indiana (City, town, or county) (State or foreign country)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Harris Gwatney
13. Birthplace Gibson County, Ind. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Harriett Barr
15. Birthplace Pike County, Ind. (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Archie Hunt
(b) Address Mexico, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof May 16, 45 (Month) (Day) (Year)
(c) Place: burial or cremation Cynthiana, Ind.
18. (a) Signature of funeral director Earl E. Parks
(b) Address Mexico, Mo.
19. (a) 5/12/45 (Date received local registrar) (b) Margaret H. Marks (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16 year 1945 hour 8 minute 20 P.M.
21. I hereby certify that I attended the deceased from 1945, to May 16, 1945; that I last saw him or alive on May 14, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocarditis	
Nephritis	
Due to Colloid Thyroid	
Due to Hypertension	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

23. Signature Frank Jolley (M. D. or other) MD
Address Mexico Mo Date signed 5/17/45

107 (Licensed Embalmer's Statement on Reverse Side)

DEC 30 1955

RECEIVED
District Health Officer No. 10
District File Number 6-45-936
Date Filed JUN 7 1945

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

Earl E. Precht, Registered Apprentice No.,

working under my personal supervision.

Signed Earl E. Precht

Licensed Embalmer No. 3189

P. O. Address Mexico, 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, fact should be so stated above.

No. 2B
M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 10 . Primary Registration District No. 3002 Registrar's No. 78

1. PLACE OF DEATH:

(a) County: Andrain

(b) City or town: Mexico
(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 years, months or days)

In this community

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: Mary E. Vandeveer

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: Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased: Oct 28 1868 (Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days 7 If less than one day hr. min.

9. Birthplace (City, town, or county) Ind (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) (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 6 year 1945 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 — Duration

Due to: Chronic interstitial nephritis

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: Frank Polley (M. D. or other)

Address: Mexico Mo Date signed 6/14/45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

16202