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 DEC 7 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37325

Registration District No. 133 Primary Registration District No. 3023 Registrar's No. 170

12 / 2

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10# hours (Specify whether years, months or days) In this community 15 years

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

3. (a) PRINT FULL NAME Iva S. Bangle
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex FEMale
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Chas W. Bangle
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased 12- (Month) 10-1878 (Day) (Year)
8. AGE: Years 66 Months 10 Days 19 If less than one day hr. min.
9. Birthplace (City, town, or county) Ohio (State or foreign country)
10. Usual occupation HouseWife
11. Industry or business
MOTHER FATHER
12. Name John Wyseman
13. Birthplace Unknown (City, town, or county) Not known (State or foreign country)
14. Maiden name Unknown
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Mary Collins
(b) Address Kansas City Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-45 (Month) (Day) (Year)
(c) Place: burial or cremation Pleasant Mound
18. (a) Signature of funeral director Osceola Funeral Home
(b) Address Osceola Missouri
19. (a) 11-10-1945 (Date received local registrar) (b) R. R. Kennedy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 26
year 1945 hour 4 minute P M.
21. I hereby certify that I attended the deceased from , 19 , to 10-26 , 1945
that I last saw her alive on 10-26 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Third Degree burns over entire body except feet.	9 hrs.
Due to: surface	
Due to:	
Other conditions (Include pregnancy within 3 months of death): ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED	
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 T. H. Taylor Jr. (M. D. or other) MD
Address Osceola, Mo. Date signed 10-26-45

1452 (Licensed Embalmer's Statement on Reverse Side)

REGISTERED

No. 7,

11-45-1173

Date filed 12-6-45

FEB 13 1959

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 J B Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola 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
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 127 Primary Registration District No. 2023 Registrar's No. 170

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

1. PLACE OF DEATH:
(a) County Henry (b) City or town Clinton
(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 Iva S. Bangle
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 M

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Years

7. Birth date of deceased Dec (Month) 10 (Day) (Year)

8. AGE: Years 66 | Months 10 | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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 Dec Day 4
year 1945 o'clock 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy

SUPPLEMENTARY

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence 10-26-45
(c) Where did injury occur? Osceola, St. Clair Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In home - 2 room, Fire.
(Specify type of place)
While at work? no. (e) Means of injury Burns

23. Signature T. H. Dangler, Jr. (M. D. or other) M.D.
Address Osceola, Mo. Date signed

37325