

BUREAU OF THE CENSUS
FILED APR 17 1947Registration District No. **107**Primary Registration District No. **20-95422**Registrar's No. **165**

1. PLACE OF DEATH:

(a) County **Bunklin**
 (b) City or town **Kennett**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
County Home 5
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 week**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

Laura Vandergriff
 3. (b) If veteran, name war **—**
 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 **—**
 6. (c) Age of husband or wife if alive **—** years
 7. Birth date of deceased **December 25 1880**
(Month) (Day) (Year)

8. AGE: Years **66** Months **3** Days **7**
 If less than one day **—** hr. **—** min.

9. Birthplace **—** **Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business **—**

MOTHER FATHER
 12. Name **—** **Edmonds**
 13. Birthplace **—** **Missouri**
(City, town, or county) (State or foreign country)
 14. Maiden name **unknown**
 15. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ocie Vandegriff**
 (b) Address **Malden, Mo.**
 17. (a) **Burial** (b) Date thereof **4-2-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Malden (New Cemetery)**

18. (a) Signature of funeral director **Lander Funeral Home**
 (b) Address **Camphers, Missouri**
 19. (a) **4-5-1947** (b) **Earl H. Hester**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Bunklin**
 (c) City or town **Malden**
(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 **—**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **2**
 year **1947** hour **—** minute **5:00 A.M.**
 21. I hereby certify that I attended the deceased from **3-27-47**
 to **4-2-47**, 19 **47**
 that I last saw him alive on **4-1-47**, 19 **47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Interstitial Nephritis**
 Due to **—**

Due to **—**
 Other conditions **—**
(Include pregnancy within 3 months of death)

Major findings: **12/13**
 Of operations **—**
 Of autopsy **—**

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? **—**

23. Signature **J. D. Simpson** (M. D. or Public Health Officer)
 Address **Kennett, Mo.** Date signed **4-5-47**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No.

District File Number 447-6

Date Filed 4-14-9

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 Christina M. Landess

Licensed Embalmer No. 4227

P. O. Address Campbell, Miss

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.

2B
45
43883

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 107

Primary Registration District No. 30194

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Keosauqua, Dunklin Co. Mo.
(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 _____ (Specify whether _____)
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

Laura Vandergriff

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 _____

7. Birth date of deceased Dec 25 1947
(Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days 25 If less than one day _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

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 _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

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

13031