. S. No. 2
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ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26968

Registration District No. FILED AUG 30 1947

Primary Registration District No. 5171

Registrar's No. 296

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Mokane (Rural) St Aubert
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: At Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway

(c) City or town Mokane (Rural)
(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 Sidney Allen Whanger

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Walda Whanger 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Nov. (Month) 23 (Day) 1890 (Year)

8. AGE: Years 56 Months 8 Days 25 If less than one day ____ hr. ____ min.

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

10. Usual occupation Farming

11. Industry or business ____

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

MOTHER
14. Maiden name Amanda Jeffries
15. Birthplace Hams Prairie (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Mrs. Walda Whanger
(b) Address Mokane, Missouri R.F.D.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-47 (Month) (Day) (Year)
(c) Place: burial or cremation Mokane

18. (a) Signature of funeral director Wallace Funeral Home
(b) Address 7 W 6th St. Fulton, Missouri

19. (a) 8-20-1947 (Date received local registrar) (b) Josie Morsinkhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 18 year 1947 hour 12 minute 30 a M.

21. I hereby certify that I attended the deceased from 8 ____, 1917, to 8 ____, 1918, that I last saw him alive on 8-17, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Cardio-Vascular Hypertension

Due to ____

Other conditions ____
(Include pregnancy within 3 months of death)

Major findings:
Of operations ____
Of autopsy ____

Duration

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 W O Payne (M. D. or other)

Address R & G Fulton Date signed 8/19/47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number AUG 29 1947
Date Filed

AUG 24 1947

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 Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address Fulton 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.