

17-47
17-39

National Office of Vital Statistics
FILED OCT 20 1947
Registration District No. **2476**

Primary Registration District No. **587-1-4387**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Alton
(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 Life time years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon **75**

(c) City or town Alton (Rural) **0**
(If outside city or town limits, write "RURAL") **0**

(d) Street No. _____ (If rural, give location) **0**

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME William Walter Vest

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 Single

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

7. Birth date of deceased May 15 1907
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>3</u>	<u>-</u>	_____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

12. Name William Henry Vest

13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Josaphine Wallace

15. Birthplace Wayne County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Otho Allen

(b) Address Alton, Mo.

17. (a) Burial (b) Date thereof 8/16/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Latter Day Saints Cem.

18. (a) Signature of funeral director Robert Carter

(b) Address Thayer, Mo.

19. (a) 9/23/47 (b) Mrs W C Johnson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 15
year 1947 hour 4 minute 45 A.M.

21. I hereby certify that I attended the deceased from Aug 16
1947, to Aug 15 1947,
that I last saw him alive on Aug 14
and that death occurred on the date and hour stated above.

Immediate cause of death Bacterial Disease

Due to	Duration
_____	_____
_____	_____
_____	_____
_____	_____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause of 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 Bl. H. Hession (M. D. or other) **(1)**

Address Alton Mo Date signed _____

Hilton

RECEIVED

District Health Officer No. 5,

District File No. 1047564

Date Filed 10-17-47

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.

Registration District No. 251

Primary Registration District No. 4389

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon
 (b) City or town allen
(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)

3. (a) PRINT FULL NAME William W. Vest

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased May 11
(Month) (Day) (Year)

8. AGE: Years 40 Months 3 Days _____
(If less than one day, hr. min.)

9. Birthplace _____
(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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

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 Chronic Hepatitis

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 W. Wilson (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

S-35190