

No. 2
-1/47
3-17-39

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

44409

State File No.

FILED JAN 26 1948

Registration District No. 152

Primary Registration District No. 201

Registrar's No.

1. PLACE OF DEATH:

(a) County JASPER

(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Freeman Hospital (1)
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 Min.
(Specify whether years, months or days)

In this community 30 Minutes

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas

(b) County Cherokee

(c) City or town Galena
(If outside city or town limits, write "RURAL")

(d) Street No. 8th & Keller
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME FANNIE GRACE VANDERPOOL

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race W.

6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife Deceased.

6. (c) Age of husband or wife if alive 25 years (Day) (Year)

7. Birth date of deceased April 25 1876
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>71</u>	<u>7</u>	<u>25</u>	hr. min.

9. Birthplace Olean New York
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Melville Robinson

13. Birthplace un-known
(City, town, or county) (State or foreign country)

14. Maiden name Josephine Crandall

15. Birthplace Un-known
(City, town, or county) (State or foreign country)

16. (a) Informant Clark Vanderpool

(b) Address Galena, Kansas.

17. (a) Removal (b) Date thereof 12-20-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galena, Kansas.

18. (a) Signature of funeral director Thornhill-Dillon

(b) Address Joplin, Mo.

19. (a) 12-23-47 (b) Dolores Sampkins, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 20 year 1947 hour 5 minute A.M.

21. I hereby certify that I attended the deceased from 12-19-47 to 12-20-47 that I last saw her alive on 12-20-47 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Left Ventricular failure

Due to long standing Hypertension

Due to Obesity Arteriosclerosis

Other conditions (Include pregnancy within 3 months of death) None

Duration

2 hrs.

20 yrs

20 yrs

PHYSICIAN

Underline the cause of which death should be charged statistically.

Major findings: Of operations None

Of autopsy None

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 C

23. Signature Robert J. Bull (M. D. or other) MD

Address Galena, Kansas Date signed 20 Dec 47

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

MOTHER FATHER

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 *Wesley Frankel*
Licensed Embalmer No. *3590*
P. O. Address *Wesley No*

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.