

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED NOV 22 1948

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **1213**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Methodist Hospital **0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **16 days** (Specify whether
In this community **50 years.** years, months or days)

3: (a) PRINT FULL NAME **Ethel M. Vannix**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **488-22-8168**

4. Sex **Female** / 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow 2**

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

7. Birth date of deceased **July 1 1884**
(Month) (Day) (Year)

8. AGE: Years **64** Months **4** Days **9** If less than one day hr. min.

9. Birthplace **Bloomington Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Cashier**

11. Industry or business **Glass House 6th & Jules St.**

12. Name **George W. Wright**

13. Birthplace **Plainfield Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Emily Crawford**

15. Birthplace **Newport Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **George G. Wright**

(b) Address **416 N. 7th St., St. Joseph, Mo.**

17. (a) **Burial** (b) Date thereof **Nov. 13, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Walter Neuhoffer**

(b) Address **1946 Colhoun St., St. Joseph, Mo.**

19. (a) **11-16-48** (b) **E. G. Jenkins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan** //
(c) City or town **St. Joseph** //
(If outside city or town limits, write "RURAL")
(d) Street No. **Geiger Apartments** //
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **10th**
year **1948** hour **9** minute **30 P. M.**

21. I hereby certify that I attended the deceased from **Oct 27**, 19**48**, to **Nov. 10**, 19**48**,
that I last saw her alive on **Nov. 10**, 19**48**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of breast**
Carcinoma of breast
Duration ?

Due to _____
Due to _____

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

Major findings:
Of operations **50**
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 **0**

23. Signature **E. G. Jenkins** (M. D. or other) _____
Address **St. Joseph, Mo.** Date signed **11-11-48**

WRITE PLAINLY—USE 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

Albert C. Harrington

Licensed Embalmer No. 3258 Missouri

P. O. Address St. Joseph, 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.