

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. 782

FILED JAN 31 1949

No. 300  
10.48

BIRTH NO. 48-47124 REG. DIST. NO. 107 PRIMARY REG. DIST. NO. 3019 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u>	
b. CITY OR TOWN <u>Kennett</u>		c. CITY OR TOWN <u>Kennett</u>	
c. LENGTH OF STAY (In this place) <u>1 day</u>		d. STREET ADDRESS (If rural, give location) <u>Box 127</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bassnell Hoah</u>			

3. NAME OF DECEASED (Type or Print) <u>Sandy Sue Vries</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>1-12-49</u>		
a. (First)	b. (Middle)	c. (Last)			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>8-18-49</u>		9. AGE (In years last birthday) <u>0</u> Months <u>4</u> Days <u>23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Miss Mo</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>Rose Vries</u>	13b. MOTHER'S MAIDEN NAME <u>Zella Padaj</u>	14. NAME OF HUSBAND OR WIFE <u>-</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Rose Vries</u>	ADDRESS <u>Miss Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Virus Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>102</u> <u>4/12</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-11, 1949, to 1-11, 1949, that I last saw the deceased alive on 1-11, 1949, and that death occurred at 1:30 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>G. G. Wilson MD</u>	23b. ADDRESS <u>Kennett Mo</u>	23c. DATE SIGNED <u>1-12-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	24b. DATE <u>1-12-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Int Zion</u>	24d. LOCATION (City, town, or county) (State) <u>Steele Mo</u>
DATE REC'D BY LOCAL REG. <u>1-18-49</u>	REGISTRAR'S SIGNATURE <u>Paul Husband</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Harmon</u> ADDRESS <u>Steele Mo</u>	

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

ED  
District Health Office No. 2,  
District File Number 149-144  
Date Filed 1-26-49

**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 \_\_\_\_\_  
Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student .....  
Student Embalmer

Signed John H. German  
Licensed Embalmer No. A355  
P. O. Address Layti, Va

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.