

FILED FEB 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 845

BIRTH NO. _____		REG. DIST. NO. <u>113</u>		PRIMARY REG. DIST. NO. <u>4185</u>		Registrar's No. <u>3</u>							
1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair Mo</u>									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. CLAIR</u>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. CLAIR Mo</u>		d. STREET ADDRESS (If rural, give location) <u>Box 346 - RR. # 3</u>							
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS									
3. NAME OF DECEASED (Type or Print) a. (First) <u>Bertha</u>			b. (Middle) <u>C.</u>		c. (Last) <u>Rowan</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 14, 1949</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct. 29, 1882</u>		9. AGE (In years last birthday) <u>66</u>		IF UNDER 1 YEAR Months <u>2</u> Day <u>15</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Vicksburg, Miss</u>			12. CITIZEN OF WHAT COUNTRY?				
13a. FATHER'S NAME <u>Thomas C. Vance</u>				13b. MOTHER'S MAIDEN NAME <u>Blanche Williams</u>				14. NAME OF HUSBAND OR WIFE <u>James</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>James Rowan St. Clair, Missouri</u>							
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Cardiovascular Disease 3 yrs</u> INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES As forbid 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. <u>4921</u>									
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>U</u>									
22. I hereby certify that I attended the deceased from <u>Dec 1</u> , 19 <u>47</u> , to <u>Jan 14</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Jan 13</u> , 19 <u>49</u> , and that death occurred at <u>7:00 A.M.</u> , from the causes and on the date stated above.													
23a. SIGNATURE <u>B. J. Strickman</u> (Degree or title)						23b. ADDRESS <u>Union, Mo</u>			23c. DATE SIGNED <u>1-15-49</u>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1-17-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co.</u>							
DATE REC'D BY LOCAL REG. <u>1-17-1949</u>		REGISTRAR'S SIGNATURE <u>E. L. Worthington</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Smith</u>		ADDRESS <u>Maplewood, Mo.</u>					

(Licensed Embalmer's Statement on Reverse Side)

Pct Paul E. Miller Deputy

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed FEB 9 1949

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 *F. C. Burgess*
Licensed Embalmer No. *4029*

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.