

FILED APR 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11395**

BIRTH NO. _____		REG. DIST. NO. 1	PRIMARY REG. DIST. NO. 3000	Registrar's No. 113
1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Adair		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville		
d. FULL NAME OF HOSPITAL OR INSTITUTION Laughlin Hospital		d. STREET ADDRESS (If rural, give location) 1416 East Patterson St.		
3. NAME OF DECEASED (Type or Print) a. (First) JOHN		b. (Middle) R.		c. (Last) VANNICE
4. DATE OF DEATH (Month) (Day) (Year) April 6, 1949				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH July 25, 1894	9. AGE (In years last birthday) 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Adair Co., Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John G. Vannice		13b. MOTHER'S MAIDEN NAME Sarah Rankin		14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mary Vannice, 1416 E. Patterson, Kirksville, Mo.
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) Cerebral Apoplexy ANTECEDENT CAUSES Hypertension Chronic nephritis DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Calcified areas in kidneys		INTERVAL BETWEEN ONSET AND DEATH 30 days ? ? 25 1/2 h
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____
22. I hereby certify that I attended the deceased from April 3, 1949 , to April 6, 1949 , that I last saw the deceased alive on April 6, 1949 , and that death occurred at 5:30 P. M. , from the causes and on the date stated above.				
23a. SIGNATURE A. J. Rhoads, D.O.		23b. ADDRESS Kirksville, Mo.		23c. DATE SIGNED 4-9-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-8-49	24c. NAME OF CEMETERY OR CREMATORY Refuge Cemetery	24d. LOCATION (City, town, or county) (State) Kirksville, Mo.
DATE REC'D BY LOCAL REG. 4-21-49		REGISTRAR'S SIGNATURE Helen Lambert		FUNERAL DIRECTOR'S SIGNATURE ADDRESS Davis Funeral Home, Kirksville, Mo.

(Licensed Embalmer's Statement on Reverse Side).

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

No. 300
10-48

AUG 21 1941

RECEIVED
District Health Officer No. _____
District File No. 449
Date Filed APR 26 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, by

..... Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed Clarence M. Billo

Licensed Embalmer No. 4375

P. O. Address Kirkville, 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.