

FILED MAY 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15206

State File No.

BIRTH NO. _____ REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 4097 Registrar's No. 662

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Harrisonville</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Austin</u>	
c. LENGTH OF STAY (In this place) <u>68 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>9 mi S.E. of Harrisonville</u>	
d. FULL NAME OF (If not in hospital or institution, give street address for location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Morris</u> b. (Middle) <u>Sherman</u> c. (Last) <u>Vansandt</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 12 1949</u>	
5. SEX <u>M. U</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 4 - 1880</u>
9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u></u> Min. <u></u>	10a. USUAL OCCUPATION (Give kind of work embracing most of work in life, even if retired) <u>Farmer retired 2 yrs</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		11. BIRTHPLACE (State or foreign country) <u>Cass Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13a. FATHER'S NAME <u>Samuel Vansandt</u>		13b. MOTHER'S MAIDEN NAME <u>Eve Ann Tipton</u>	
14. NAME OF HUSBAND OR WIFE <u>Mrs. Lois Vansandt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. M.S. Vansandt</u>		ADDRESS <u>Hvilla</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute PANCREATITIS</u>		ANTECEDENT CAUSES DUE TO (b) <u>Acute Cholecystitis & Cholelithiasis UNKNOWN</u>		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>5890</u>

19a. DATE OF OPERATION <u>May 8 1949</u>	19b. MAJOR FINDINGS OF OPERATION <u>Acute PANCREATITIS & Acute Cholelithiasis</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE <u>✓</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>✓</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Harrisonville Cass Missouri</u>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>✓ - - - m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>✓</u>		

22. I hereby certify that I attended the deceased from May 8, 1949, to May 12, 1949, that I last saw the deceased alive on May 13, 1949, and that death occurred at 5:25 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>J.P. Dargatzis</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Harrisonville Mo</u>	23c. DATE SIGNED <u>May 14 1949</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>May 15 49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Orient</u>	24d. LOCATION (City, town, or county) (State) <u>Harrisonville Mo</u>
DATE REC'D BY LOCAL REG. <u>May 14, 1949</u>	REGISTRAR'S SIGNATURE <u>Sandra J. Jones</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>51</u>	ADDRESS <u>Harrisonville</u>

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

No. 300
10-48

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

Bill J. Drakey

Student Embalmer No. *254*

working under my personal supervision.

Student
Student Embalmer

Signed *Floyd Atkinson*

Licensed Embalmer No. *3920*

P. O. Address *Harrisonville*

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.

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