

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 389 PRIMARY REG. DIST. NO. 5163

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Callaway</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u> | |
| b. CITY OR TOWN <u>Rural-Cote San Drossin TWP</u> | | c. CITY OR TOWN <u>Rural-Cote San Drossin TWP</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6 mi SE - New Bloomfield Mo.</u> | | d. STREET ADDRESS (If rural, give location) <u>6 mi SE - New Bloomfield Mo.</u> | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Harvey</u> b. (Middle) _____ c. (Last) <u>Wangley</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 21 52</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>Nov 20 - 1894</u> |
| 9. AGE (In years) (last birthday) <u>57</u> (Months) <u>2</u> (Days) <u>1</u> (Hours) _____ (Mins.) _____ | | 11. BIRTHPLACE (City and State or Foreign Country) <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired P. Health</u> | |
| 11. BIRTHPLACE (City and State or Foreign Country) <u>Cole Co. Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Thomas Wangley</u> | | 13b. MOTHER'S MAIDEN NAME <u>Ameriea Wangley</u> | |
| 14. NAME OF HUSBAND - OR WIFE <u>Louise</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes W.W.I.</u> | |
| 16. SOCIAL SECURITY NO. <u>NO</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Paterns Discharge Office</u> ADDRESS <u>Jeff. City Mo.</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Valvular Heart Disease</u> ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last... 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>4214</u> | |
| 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) _____ (Mins.) _____ | | 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 <u>April 9, 1952</u> , to <u>Jan 21, 1962</u> , that I last saw the deceased alive on <u>Jan 16, 1962</u> , and that death occurred at <u>8:30 a.m.</u> , from the causes and on the date stated above. | |
| 23a. SIGNATURE <u>O. E. Meserick M.D.</u> (Degree or title) | | 23b. ADDRESS <u>New Bloomfield Mo</u> | |
| 23c. DATE SIGNED <u>Jan 23-52</u> | | 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | |
| 24b. DATE <u>Jan 23-52</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>National Cemt</u> | |
| 24d. LOCATION (City, town, or county) (State) <u>Jefferson City Mo</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Holt Claypool</u> ADDRESS <u>Scr. N.B. Mo</u> | |
| DATE REC'D BY LOCAL REG. <u>Jan 23-52</u> | | REGISTRAR'S SIGNATURE <u>LeRoy Claypool</u> 39 | |

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

0140

0140

REC. LE. MAR.

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 LeRoy Claypool

Licensed Embalmer No. 4412

P. O. Address New Bloomfield

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.