No. 300
10.48

FILED DEC 15 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38490

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 5552 Registrar's No. 34

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

1. PLACE OF DEATH
a. COUNTY: HOWELL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Koshkonong rural
c. LENGTH OF STAY (In this place): 46 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Howell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Koshkonong 0460
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): VASHTI
b. (Middle):
c. (Last): VINCENT

4. DATE OF DEATH (Month) (Day) (Year): Nov. 30, 1952

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Oct. 31, 1884
9. AGE (In years last birthday): 68 — If under 1 year: Months / Days 29 — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): Fulton Co., Ark.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: George Haney
13b. MOTHER'S MAIDEN NAME: Jane Blagg
14. NAME OF HUSBAND OR WIFE: WAlker Vincent

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: WAlker Vincent — ADDRESS: Koshkonong, 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) Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ??

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: 4214
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Pollard Drist M.D. Coroner
23b. ADDRESS: West Plains, Mo — Howell Co
23c. DATE SIGNED: 8 Dec 52

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 12-4-52
24c. NAME OF CEMETERY OR CREMATORY: Shiloh Cemetery
24d. LOCATION (City, town, or county) (State): Koshkonong Mo.

DATE REC'D BY LOCAL REG.: 12-9-52
REGISTRAR'S SIGNATURE: Beatrice Cook 379
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Leland Carter, Thayer Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 Lillard Carter

Licensed Embalmer No. 4516

P. O. Address Thayer 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.