Health, Welfare Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 35269

FILED OCT 21 1957 Registration District No. 93 Primary Registration District No. 4154 Registrar's No. 57-74

1. PLACE OF DEATH a. COUNTY Dade	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Dade
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Greenfield Mo — Inside Limits Yes X No ☐	c. CITY OR TOWN Greenfield Mo 0290 — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
Anna	C	Travis	Oct.14,1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
F	W		Oct 25,1884	72	11 19	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
House Wife		Ceder Co Mo	usa

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Winfield Vancamp	Frankie Vancamp

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	Address
no		none	Ray Travis	Greenfield Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Valvular heart condition

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) accompanied by a

DUE TO (c) hospital condition

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4214

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐	SUICIDE ☐	HOMICIDE ☐	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY	Hour a. m. p. m.	Month, Day, Year	

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE

21. I attended the deceased from Jan. 1 to 10-14-57 and last saw her alive on 10-13-57

Death occurred at 1:15a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
W. S. Burney M.D.	Miller Mo	10-16-57

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	Oct 16 1957	Hickory Grove	Dade Co Mo

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
W.R. Allison	Greenfield Mo.	10-17-57	J. C. Canada

(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 em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed W.R. Allison

Licensed Embalmer No. 44

P. O. Address Springfie

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.