

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-028274

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 301 Primary Registration District No. _____ Registrar's No. 48

FILED JUL 24 1962

VS 300
Rev. 4/59

1 0910
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9331X
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12 90-0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Ripley</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Ripley</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Doniphan</u>		Length of stay in 1b <u>YEARS</u>	c. CITY OR TOWN <u>Doniphan</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 2</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>JANE</u> Last <u>VANCE</u>			4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1962</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-19-1877</u>
9. AGE (last birthday) <u>82</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Dent Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>HARM Shockley</u>	
13b. MOTHER'S MAIDEN NAME <u>Betsy MAXEN</u>		14. NAME OF HUSBAND OR WIFE <u>William Oliver VANCE</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>HOUSE BEAR</u>	17. INFORMANT <u>Doniphan, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>CVA</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>6-20-62</u> to <u>7-6-62</u> and last saw her/him alive on <u>7-6-62</u> Death occurred at <u>1:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Gene H. Leary, M.D.</u>		22b. ADDRESS <u>Doniphan, Mo</u>	
22c. DATE SIGNED <u>7-9-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>7-8-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Doniphan Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Doniphan, Missouri</u>	
24. FUNERAL DIRECTOR <u>Edwards Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>7-8-62</u>	
ADDRESS <u>Doniphan, Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Flava Broz.</u>	

USE BLACK INK OR TYPEWRITER RIBBON

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 _____
Signature of Student Embalmer

Signed *Ronald Sloan*

Licensed Embalmer No. 5127

P. O. Address *Doriphan, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

Permit issued 7-8-62
no. 21