

1939 MAR 15

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

6168
Do not use this space.

1. PLACE OF DEATH *Cass*

(a) County *Cass* Registration District No. *15B*

(b) Township _____ Primary Registration District No. *4090*

(c) City *Harrisonville* (d) Street No. *Memorial Hospital* Registered No. *9*

(e) Length of residence in city or town where death occurred *18* yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Mary Olive Van Camp*

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female*

4. COLOR OR RACE *White*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Lease Van Camp*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 22-1867*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *71 3 17*

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Home-maker*

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Indianna*

FATHER 13. NAME *John T. White*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Indiana*

MOTHER 15. MAIDEN NAME *Nancy Bradley*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) *Mrs. Effie Perkins 1014 Sandusky K. C. Kans*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Orion Cemetery* DATE *7/11 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *RUNNENBURGER'S HARRISONVILLE, MO.*

20. FILED *2-10 1939* *K. W. S. Local Registrar*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 9 1939*

22. I HEREBY CERTIFY that I attended deceased from *Jan 20 1939* to *Feb 9 1939*

I last saw her alive on *Feb 8 1939* Death is said to have occurred on the date stated above, at *19:45 A.M.*

The principal cause of death and related causes of importance were as follows:

*Mitral Regurgitation
Chronic Myocarditis*

Date of onset _____

Other contributory causes of importance: *92*

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) *J. P. Seath* M. D.

(Address) *Harrisonville Mo*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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 _____

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Ernest Reimnburger

Licensed Embalmer No. 3368

P. O. Address Harrisonville 7

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

6168
Do not use this space.

1. PLACE OF DEATH

(a) County Cass Registration District No. 15-6
(b) Township _____ Primary Registration District No. 4096 Registered No. 9
(c) City Harrisonville (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Mary Ollie Van Kamp
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-9-1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
71 3 17

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spent in this occupation _____

Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME _____

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME Wesley Bentley

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____, 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 2/10 1939 W. S. Bentley M.D. Local Registrar.

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____ (Signed) J. H. Scott _____, M. D.
(Address) Harrisonville, Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Supplemental

