

REGD MAR 20 1939

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

Mo. Reg. 585
Do not use this space.

1. PLACE OF DEATH

(a) County Randolph Registration District No. 73
(b) Township Jacksonville Primary Registration District No. 4439 Registered No. _____
(c) City Jacksonville (d) Street No. _____ St. _____
(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

522 Ella J Vansickle
(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 25, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1939, to Feb 20, 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 30 1862

I last saw h.e.r. alive on Feb 20, 1939. Death is said to have occurred on the date stated above, at 3:35 a.m.

7. AGE YEARS 76 MONTHS 3 DAYS 25 If LESS than 1 day, _____ hrs. or _____ min.

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. housewife
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 _____

Bronchial pneumonia
Cerebral hemorrhage
Date of onset Feb 18, 1939
Feb 18, 1939
G.F.W.

12. BIRTHPLACE (CITY OR TOWN) Rails Co (STATE OR COUNTRY) Mo

Other contributory causes of importance:
Hypertension
Arteriosclerosis

FATHER 13. NAME Clintore McGraw

Name of operation _____ Date of _____
What test confirmed diagnosis? Physical exam Was there an autopsy? NO

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

MOTHER 15. MAIDEN NAME Angelina Spencer

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)

16. BIRTHPLACE (CITY OR TOWN) Rails Co (STATE OR COUNTRY) Missouri

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

17. INFORMANT (ADDRESS) Mrs Carl Dowdling
Jacksonville Mo

Manner of injury _____
Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Friendship Cem DATE Feb 27, 1939

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____

19. FUNERAL DIRECTOR (NAME) Robert S Keene (ADDRESS) Macon Mo

(Signed) Ed Kossinger M. D.
(Address) 118 1/2 W. 1st St Macon, Mo.

20. FILED _____ 19 _____ Local Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATE OF MISSOURI
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

RECEIVED
District Health Officer No. 10
District File Number 10-39-342
Date Filed: MAR 14 1939

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, Geo. V. Kilo, or by

Registered Apprentice No., working under my personal supervision.

Signed: Geo. V. Kilo

Licensed Embalmer No. 4066

P. O. Address: Macon, 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, 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

75-85-
Do not use this space.

1. PLACE OF DEATH
 (a) County Randolph Registration District No. 734
 (b) Township Jacksonville Primary Registration District No. 4439
 (c) City Jacksonville (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 Ella J Vansickle
 (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
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-80-1862
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
76 3 25
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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 _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 25, 1939
 22. I HEREBY CERTIFY, That I attended deceased from 2-20 to Feb 20, 1939
 I last saw her alive on Feb 20, 1939. Death is said to have occurred on the date stated above, at 3-9 m.
 The principal cause of death and related causes of importance were as follows:
Bacterial pneumonia Date of onset _____
Cerebral Hemorrhage
 Other contributory causes of importance:
Hypertension
arterio sclerosis

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo
 FATHER 13. NAME Clinton Mc Brew
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo
 MOTHER 15. MAIDEN NAME Angeline Preece
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo
 17. INFORMANT (ADDRESS) Mrs Carl Dowding
Jacksonville
 18. BURIAL, CREMATION, OR REMOVAL PLACE Friendship DATE Feb 27, 1939
 19. FUNERAL DIRECTOR (ADDRESS) Albert Skinner
macon mo
 20. FILED April 19, 1939 John Wigh
 Local Registrar.

Name of operation _____ Date of _____
 What test confirmed diagnosis? Physical 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) E. J. Hordinger M. D.
 (Address) macon mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

