

FULL MAY 13 1940

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

14186  
Do not use this space.

1. PLACE OF DEATH

(a) County Andrew Registration District No. 72  
(b) Township Kilson Primary Registration District No. 5037 Registered No. 9  
(c) City ..... (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

Joseph Henry Vauvacter  
(a) Residence, No. .... St. ....  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Martha Vauvacter  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 29 - 1861  
7. AGE YEARS 78 MONTHS 5 DAYS 12 If LESS than 1 day, hrs. or min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
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) Roeder Va

FATHER 13. NAME Cyrus A. Vauvacter

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

MOTHER 15. MAIDEN NAME Leslie

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

17. INFORMANT (ADDRESS) Mrs J H Vauvacter Centralia Mo

18. BURIAL, CREMATION, OR REMOVAL Centralia Mo Cem DATE Apr 14 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) M J McDonald Centralia Mo

20. FILED 4/13 19 40 F H Barden M.D. 892 Address Centralia Mo  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 12th 1940  
22. I HEREBY CERTIFY, That I attended deceased from Apr 5th 1940 to Apr 12th 1940  
I last saw h. in alive on Apr 11th 1940 Death is said to have occurred on the date stated above, at ..... m.  
The principal cause of death and related causes of importance were as follows:

Acute dilatation  
Hypostatic pneumonia  
Date of onset 4/3  
Date of death 4/10  
Other contributory causes of importance:  
Chronic myocarditis  
Hypertension

Name of operation ..... Date of .....  
What test confirmed diagnosis? Phys. Exam an autopsy? no

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? no  
If so, specify .....  
(Signed) J H Barden, M. D.  
Address Centralia Mo

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

930

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.....

*MD McDaniel*

Licensed Embalmer No.....

*2589*

P. O. Address.....

*Centralia 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.**

Registration District No. 72

Primary Registration District No. 2037

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Anderson  
(b) City or town Wilson  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U.S.A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

Joseph Henry Vanacore

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 13 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business.

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace. (City, town, or county) (State or foreign country)  
14. Maiden name. (City, town, or county) (State or foreign country)  
15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month Apr day 12 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death acute dilatation of hypostatic pneumonia  
Due to Tobac  
Due to 10

Other conditions Chronic Hypo Carditis  
Hypertension  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. M. Gupner (M. D. or other) \_\_\_\_\_  
Address Centralia signed \_\_\_\_\_

SUPPLEMENTAL

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

ROWEN?

