

FILED JUN 12 1943

Registration District No. 188

Primary Registration District No. 3038

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Brookfield Hosp. O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 Days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County MACON
(c) City or town NEW CAMBRIA
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME THOMAS VANTINE

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Hannah Vantine 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased September 9 1866
(Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation Carpenter

11. Industry or business _____

12. Name Joseph Vantine
13. Birthplace CHAYLTON Co Mo
(City, town, or county) (State or foreign country)
14. Maiden name Maria Lambert
15. Birthplace CHAYLTON Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. H. Pate
(b) Address New Cambria Mo
17. (a) Burial (b) Date thereof 5-28-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New Cambria

18. (a) Signature of funeral director H. P. Hillland
(b) Address New Cambria Mo
19. (a) 5-26-1943 (b) W. W. Canan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26
year 1943 hour 11 minute 50 P.M.
21. I hereby certify that I attended the deceased from May 14 1943 to May 26 1943
that I last saw him alive on 5-26 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis 2 yrs
Chronic Int. Neph 5 yrs
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) None
Major findings: Of operations None
Of autopsy _____

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 Chas. Brock (M. D. or other) _____
Address Brookfield Date signed 5/26

Duration
2 yrs
5 yrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.