

FILED FEB 27 1944

Registration District No. 4

Primary Registration District No. 4057

Registrar's No. 18

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

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Julin
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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

3. (a) PRINT FULL NAME IRENE VANCIL

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 4 years

7. Birth date of deceased mch. 13 1913
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

30 10 6 hr. _____ min.

9. Birthplace Malden, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER { 12. Name W.E. Vancil

13. Birthplace Benton, Ill. 1
(City, town, or county) (State or foreign country)

14. Maiden name Geneva Summers

15. Birthplace Malden, Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant W.E. Vancil

(b) Address Julin, Mo.

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-17-44 (b) Belle Turner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler ¹²

(c) City or town Julin ⁰
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 7
year 1944 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 3rd 1944 to Jan 7 1944
that I last saw her alive on Jan 3rd 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Pulmonary Tuberculosis Duration 13 yrs

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

13 fl

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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature Wallace Nelson (M. D. or other) MD.
Address Camperel Mo. Date signed 1/8/44

RECEIVED

District Health Office No. 2,

District File Number 144-189

Date Filed 1-25-44

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 43

Primary Registration District No. 4057

Registrar's No. 18

1. PLACE OF DEATH:

(a) County.....

(b) City or town.....
(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)

3. (a) PRINT FULL NAME Irene Vancil

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex.....

5. Color or race.....

6. (a) Single, widowed, married, divorced.....

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 Months Days If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a) Burial (b) Date thereof 1-10-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Malden Cemetery

18. (a) Signature of funeral director Lloyd Kinnear

(b) Address Biggs St., Ark.

19. (a) 1-24-44 (b) Bille Kinnear
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January, year 1944, hour..... minute..... M.

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

Immediate cause of death.....

Duration.....

Due to.....

Due to.....

Other conditions:.....
(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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number _____

Date Filed _____

2231