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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6711**

FILED MAR 9 1946

Registration District No. **275**

Primary Registration District No. **5942**

Registrar's No. **33**

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

1. PLACE OF DEATH:

(a) County **Shelby**

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

(c) Name of hospital or institution **Rolla Hosp. 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 **5 yrs**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Shelby**

(c) City or town **Rolla**
(If outside city or town limits, write "RURAL")

(d) Street No. **Ravine 1**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Minnie Anne Vankirk**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **28**
year **1946** hour **6:50** minute **P** M.

21. I hereby certify that I attended the deceased from **1-1**
1946, to **1-28**, **1946**

that I last saw her alive on **1-28**, **1946**
and that death occurred on the date and hour stated above.

4. Sex **M**

5. Color or race **W**

6. (a) Single, widowed, married, **2 divorced Widow**

6. (b) Name of husband or wife **John H. Vankirk**

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

7. Birth date of deceased **Oct. 25, 1876**
(Month) (Day) (Year)

Immediate cause of death **Chronic myocarditis - congestive failure**

Duration **2 wks**

Due to _____

Due to _____

Other conditions **Pneumonia**
(Include pregnancy within 3 months of death)

8. AGE:

Years	Months	Days	If less than one day
69	3	3	hr. _____ min. _____

Major findings:
Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

9. Birthplace **Beulah Shelby Co. Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **John Samuel Sanning**

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

14. Maiden name **Rebecca Mearns**

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

16. (a) Informant **Mr. George Patten**

(b) Address **Beulah City Mo**

17. (a) Burial, cremation, or removal **Burial**

(b) Date thereof **Jan 31, 1946**
(Month) (Day) (Year)

(c) Place: burial or cremation **Beaver Dam**

18. (a) Signature of funeral director **W. L. Dean**

(b) Address **508 W. 8th Rolla Mo**

19. (a) Feb. 5, 1946 (Date received local registrar)

(b) Mrs. Juanita Harvey (Registrar's signature)

22. If death was due to external cause, specify 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 **E. E. Feild M.D.** (M. D. or other)

Rolla Mo. Date signed **2-1-46**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *S. b. V. Jones*.....

Licensed Embalmer No. *3394*.....

P. O. Address..... *Rolla 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Mar
Registrar's No. 33

Registration District No. 275 Primary Registration District No. 5942

1. PLACE OF DEATH:

(a) County Phelps Rural
(b) City or town Rural
(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) (Specify whether

3. (a) PRINT FULL NAME Minnie A. Vanhook

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 wid

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

7. Birth date of deceased Oct 25
(Month) (Day) (Year)

8. AGE: Years 69 Months _____ Days _____ If less than one day hr. _____ min. _____

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

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (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 _____ Day _____ Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration _____

Due to _____

Due to Pneumonia - bronchial

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

Major findings: Of operations _____

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) (a) Means of injury _____

23. Signature Ed. F. ... (M.D. or other) _____

Address Rolla Mo Date signed 10/2/46

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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