

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
FILED 21 1946
STANDARD CERTIFICATE OF DEATH

State File No. **33390**

Registration District No. **141** Primary Registration District No. **3025** Registrar's No. **86**

1. PLACE OF DEATH:

(a) County **Haskell**
 (b) City or town **West Plains**
 (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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Haskell**
 (c) City or town **West Plains**
 (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 **Cornelius Clossius Van Wort**
 (b) If veteran, name war
 (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **2**
 year **1946** hour **11** minute **25 P.** M.
21. I hereby certify that I attended the deceased from
25 Sept 1946 to 2 Oct 1946
 that I last saw him alive on **25 Sept 1946**
 and that death occurred on the date and hour stated above.

4. Sex **MO** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M**
 6. (b) Name of husband or wife **Sarah Van Wort** 6. (c) Age of husband or wife if alive **82** years
 7. Birth date of deceased **3 22 1864**
 (Month) (Day) (Year)

Immediate cause of death
Serious Bacterial
Chr. Hypertrophic Arthritis
Inguinal Hernia - Bilateral (old)

8. AGE: Years **82** Months **6** Days **10** If less than one day _____ hr. _____ min.

Due to _____
 Due to _____
 Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy _____

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

10. Usual occupation: **Farmer**

11. Industry or business: _____
12. Name: **C. Van Wort**
13. Birthplace: _____ (City, town, or county) (State or foreign country)
14. Maiden name: **Davis**
15. Birthplace: _____ (City, town, or county) (State or foreign country)

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 _____ (Specify type of place) (e) Years of injury _____
23. Signature: _____ (M. D. or other) _____
 Address **West Plains, Mo** Date **2 Oct 46**

16. (a) Informant: **Sarah Van Wort**
 (b) Address **West Plains, Mo**
17. (a) B (b) Date thereof **10-4-46**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Evergreen Cem.**
18. (a) Signature of funeral director: **Roberts**
 (b) Address **West Plains, Mo**
19. (a) Oct 8, 1946 (b) **Blady Harrison**
 (Date received local registrar) (Registrar's signature)

PHYSICIAN
 Underline the cause to which death should be charged statistically.
122A

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File Number 10465-65

Date Filed 10-12-46

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 J. L. Duncan, Registered Apprentice No. 390 working under my personal supervision.

Signed A. D. Robertson

Licensed Embalmer No. 3432

P. O. Address West Plains, 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.