

No. 2
5-43
5-17-39
I. X36671

FILED AUG 16 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28651

Registration District No. 290

Primary Registration District No. 4427

Registrar's No. 94

1. PLACE OF DEATH:

(a) County PULASKI
(b) City or town WAYNESVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
DEWITT HOSPITAL 0
(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 MISSOURI (b) County DENT 38
(c) City or town SALEM 1
(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 _____

3. (a) PRINT FULL NAME EDWIN HEWSON VAN PELT

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced M 1

6. (b) Name of husband or wife ROSE 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JULY 12 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 0 28 hr. min.

9. Birthplace LEXINGTON KY 1
(City, town, or county) (State or foreign country)

10. Usual occupation U.S. Postal Service

11. Industry or business _____

12. Name WILLIAM D. VAN PELT

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

14. Maiden name EVA M. TRAPP 4
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph W. Van Pelt

(b) Address Salem, Mo.

17. (a) Burial (b) Date thereof 8/13/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SALEM, MO

18. (a) Signature of funeral director Carl F. Spencer

(b) Address SALEM, MO

19. (a) Aug. 14, 1947 (b) Thelma C. Buchholz
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 10
year 1947 hour 9:00 minute A M.
21. I hereby certify that I attended the deceased from 8-7-47 to 8-10-47, 19____
that I last saw him alive on 8-10-47, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Prostatic Carcinoma
Due to Carcinoma Metastatic
Due to Carcinoma Colon

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

Major findings: Of operations H/E
Of autopsy _____

Duration _____
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 C. F. Shelly (M. D. or other) NO
Address Waynesville Date signed 8-10-47

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

MOTHER FATHER

SEP 3 1947

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, by

....., Registered Apprentice No.
working under my personal supervision.

Signed Wm. W. McDonald

Licensed Embalmer No. 3806

P. O. Address Salem, 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.

Registration District No. 290 Primary Registration District No. 4427

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(a) County Pulaski
(b) City or town Waynesville
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Edwin H Van Pelt

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 _____

7. Birth date of deceased July 12 (Month) (Day) (Year)

8. AGE: Years 77 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business U.S. Postal Service until retirement age

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1947 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 _____

Due to _____

Due to _____

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) (e) Means of injury _____

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

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

NOV 4 1947
NOV 4 1947
NOV 4 1947

S-28651