No. 2
8-43
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X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 7 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31680

Registration District No. 169 Primary Registration District No. 4259 Registrar's No. 164

1. PLACE OF DEATH:

(a) County Knox City
(b) City or town Newark
(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 3 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 52
(c) City or town — 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JESSE Vanskike
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 Widower
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 25 (Day) 1857 (Year)

8. AGE: Years	Months	Days	If less than one day
90	8		hr. min.

9. Birthplace Knox County Mo (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Steve Vanskike
13. Birthplace unknown 9 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Sallie Todd
15. Birthplace unknown 9 (City, town, or county) (State or foreign country)
16. (a) Informant Maude Latimer
(b) Address Newark, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Shiloh Shelby Co.
18. (a) Signature of funeral director Thomas Ball
(b) Address Ewing Mo
19. (a) Sept 29-47 (Date received local registrar) (b) Nell S. Hurst (Registrar's signature) 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25
year 1947 hour 6 minute 20 A.M.
21. I hereby certify that I attended the deceased from June 8, 1947, to Sept 25, 1947;
that I last saw him alive on Sept 25, 1947;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Hypertension	
Due to Renal damage	
Other conditions (Include pregnancy within 3 months of death) Kenneth Glover DO	
Major findings: Of operations	
Of autopsy 83A	

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 2
23. Signature Kenneth Glover (M.D. or other) DO
Address Newark Mo. Date signed 9-25-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 1
District File Number 10-47-135
Date Filed OCT - 6 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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Thomas Ball

Licensed Embalmer No. 1794

P. O. Address Ewing, Neb

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
I—3-45
P I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 169 Primary Registration District No. 4259 Registrar's No. 164

1. PLACE OF DEATH:
(a) County Knox City
(b) City or town Newark
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (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 Jesse VanSkike
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 Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan 25 (Month) (Day) (Year)
8. AGE: Years 90 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) Nell S. Stewart (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 27 year hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-31680