

1. PLACE OF DEATH:  
(a) County: Mercer  
(b) City or town: Princeton  
(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: all his life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State: MO (b) County: Mercer  
(c) City or town: Princeton (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:

65  
1  
0  
0

3. (a) PRINT FULL NAME: Roy V. Vanderpool  
3. (b) If veteran, name war: World War 1  
3. (c) Social Security No.:

4. Sex: male  
5. Color or race: White  
6. (a) Single, widowed, married, divorced: Div  
6. (b) Name of husband or wife:  
6. (c) Age of husband or wife if alive: years  
7. Birth date of deceased: Nov. 13, 1896  
(Month) (Day) (Year)

8. AGE:  
Years: 52  
Months: 2  
Days: 13  
If less than one day

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

10. Usual occupation: farmer

11. Industry or business: William Vanderpool  
12. Name:  
13. Birthplace: Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name: Winsel  
15. Birthplace: Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant: William Vanderpool  
(b) Address: Princeton, Mo.  
17. (a) burial (b) Date received: 1-27-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation: Pine

18. (a) Signature of funeral director: Noel Moss  
(b) Address: Princeton, Mo.  
19. (a) 1-27-48 (b) M. J. Roth  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month: Jan day: 26  
year: 1948 hour: 7 minute: 30 A.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.

Immediate cause of death:  
Probably a heart lesion when he was found dead at 7:30 A.M. - in bed room  
Other conditions:  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations:  
Of autops:  
PHYSICIAN  
Underline the cause of 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)  
Means of injury:  
23. Signature: [Signature] (M. D. Coroner)  
Address: Princeton Date signed: 1-27-48

WRITE PLAINLY—USING UNFADING INK—FEB-9-1948 PERMANENT RECORD

MOTHER FATHER

FEB 18 1948

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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..... *Paul Moss*

Licensed Embalmer No. *2634*

P. O. Address *Clinton 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.

2B  
3-45  
4380

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7-2  
Registrar's No. 107

Registration District No. 210

Primary Registration District No. 4223

1. PLACE OF DEATH:

(a) County Merces  
(b) City or town Princeton  
(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  
In this community all his life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Roy V. Vandepas

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 divorced

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) "Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Nov 13 1907  
(Month) (Day) (Year)

8. AGE: Years 52 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 \_\_\_\_\_ (Burial, cremation, or removal) (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 \_\_\_\_\_ Year 1944 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 \_\_\_\_\_

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

S-1803