

FILED JUL 26 1948

Registration District No. **290**

Primary Registration District No. **5986**

Registrar's No. **88**

1. PLACE OF DEATH:

(a) County **Pulaski**
 (b) City or town **Tavern Twp. Rural**
 (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 **50 years**
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Bulaski** **85**
 (c) City or town **Rural** **0**
 (If outside city or town limits, write "RURAL") **0**
 (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 **Lou Minne Vandergriff**

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 **Single**

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

7. Birth date of deceased **Feb. 14 1876**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	4	27	0
				hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Isaac Vandergriff** **9**
 13. Birthplace **D.K.** (State or foreign country)
 14. Maiden name **Mary Forbes** (State or foreign country)
 15. Birthplace **D.K.** (State or foreign country)

16. (a) Informant **Geo. Vandergriff**
 (b) Address **Crocker, Mo.**

17. (a) **Burial** (b) Date thereof **July 13, 48**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Tyler Cemetery**

18. (a) Signature of funeral director **J.L. Hoops & Sons**
Crocker, Mo.

(b) Address _____
 19. (a) **7-24-48** (b) **Delma C. Buckner**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **11**
 year **1948** hour **10:30** minute **P** M.

21. I hereby certify that I attended the deceased from **July 11** 19**48** to **July 11** 19**48**
 that I last saw her alive on **July 11** 19**48**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia, terminal 8 days**

Due to **Diabetic Metabolism 18 yrs.**

Due to **Arterial Sclerosis 40 yrs.**

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

Major findings: Of operations **none made**

Of autopsy **61**

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? **X**

While at work? _____ (Specify type of place)
 (e) Means of injury **0**

23. Signature **C. Mallory** (M. D. or other) **M.D.**
 Address **Crocker, Mo.** Date signed **7-15-48**

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 B. Koop

Licensed Embalmer No. 3261

P. O. Address Greene, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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. July

857

Registration District No. 290

Primary Registration District No. 5986

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pulaski
 (b) City or town _____
 (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)

3. (a) PRINT FULL NAME

Lex M. Vandergriff

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 S

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

7. Birth date of deceased 7-21
 (Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

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 1948 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ live 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) (c) Means of injury _____

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

Address _____ Date signed _____

SUPPLEMENTARY

MAKE A PERMANENT RECORD

B7 45 3880

5-23890