No. 300
10.48

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

FILED JUN 25 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19844

BIRTH NO. _____ REG. DIST. NO. 33 PRIMARY REG. DIST. NO. 3010 Registrar's No. 313

1. PLACE OF DEATH
a. COUNTY: Cape Girardeau
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cape Girardeau
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Francis Hpl

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Dunklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malden
d. STREET ADDRESS (If rural, give location): 411 E Ozark

D 35 1

3. NAME OF DECEASED (Type or Print): a. (First) Charlette b. (Middle) T c. (Last) Vantrease

4. DATE OF DEATH (Month) (Day) (Year): 6-10-1956

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: May-8-1953
9. AGE (In years last birthday): 3-1-2 | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and State or Foreign Country): Malden Mo
12. CITIZEN OF WHAT COUNTRY?: US

13a. FATHER'S NAME: Leo Vantrease
13b. MOTHER'S MAIDEN NAME: Ruth Glover
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No
17. INFORMANT'S SIGNATURE OR NAME: Leo Vantrease | ADDRESS: Malden Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ENCEPHALITIS — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10 June, 1956, *to* 10 June, 1956, *that I last saw the deceased alive on* 10 June, 1956, *and that death occurred at* 6:23 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: James A. Kinder (Degree or title) M.D.
23b. ADDRESS: Cape Girardeau Mo.
23c. DATE SIGNED: 13 June 56

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6-11-56
24c. NAME OF CEMETERY OR CREMATORY: Malden Park Memorial
24d. LOCATION (City, town, or county) (State): No Malden Mo

DATE REC'D BY LOCAL REG.: 6-20-56
REGISTRAR'S SIGNATURE: Elizabeth Sommer Dep
25. FUNERAL DIRECTOR'S SIGNATURE: Thomas E. Knight | ADDRESS: Malden Mo

(Licensed Embalmer's Statement on Reverse Side)

H-0

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.....

....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed William E Freer

Licensed Embalmer No. 4733

P. O. Address Cape Girardeau 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.