

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **9522**

FILED MAR 18 1957

BIRTH NO. _____		REG. DIST. NO. <u>247</u>		PRIMARY REG. DIST. NO. <u>4366</u>		Registrar's No. <u>12</u>	
1. PLACE OF DEATH a. COUNTY <u>Newton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Newton</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Granby</u>		c. LENGTH OF STAY (in this place) <u>5 yrs</u>		c. CITY OR TOWN <u>Stella (1 1/2 M.E.)</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Kimbrough Rest Home</u>				• STREET ADDRESS (If rural, give location) <u>1 1/2 Miles northeast of Stella</u>			
3. NAME OF DECEASED (Type or Print) <u>Charley</u>		a. (First) <u>Harrison</u>		b. (Middle) <u>Vanslyke</u>		c. (Last) _____	
4. DATE OF DEATH <u>March 9 1957</u>		5. SEX <input type="radio"/> Male <input type="radio"/> Female		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Aug. 5. 1876</u>		9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>4</u> Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Newton County Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Harrison Vanslyke</u>		13b. MOTHER'S MAIDEN NAME <u>Amelia Jane Rickner</u>		14. NAME OF HUSBAND OR WIFE <u>Crissie Ethridge Vanslyke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John Vanslyke, Stella Missouri</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Fracture Left arm</u> ANTECEDENT CAUSES <u>Senility with</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Mention of Senile Dementia</u> 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.				INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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) <u>073</u> (COUNTY) _____ (STATE) _____		_____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>1-12-1957</u> , to <u>3-9-1957</u> , that I last saw the deceased alive on <u>3-7-1957</u> , and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above.							
23a. SIGNATURE <u>Melvin M. Cullough</u> (Degree or title) <u>2</u>				23b. ADDRESS <u>424 W. Sherman St. Stella Mo</u>		23c. DATE SIGNED <u>3/11/57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3/10/1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Macedonia Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Stella Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Mar. 11, 1957</u>		REGISTRAR'S SIGNATURE <u>M. L. Young</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. Thomas Home Wheaton Mo</u>			

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

225  
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RECEIVED

District Health Officer No. *Newton*

District File Number *357-59*

Date Filed *MAR 14 1957*

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.....  
Signature of Student Embalmer

Signed *James Kenneth Duncan*

Licensed Embalmer No. *4767*

P. O. Address *Wheaton M*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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

*No arterial was done on body due to circulatory system and condition of body. Pack and cavity injection was all the preservation*  
*James Kenneth Duncan*