SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-009641
STATE FILE NUMBER

AMENDED

Registration District No. 179 Primary Registration District No. 4287 Registrar's No. 43

FILED APR 10 1961

1. PLACE OF DEATH
a. COUNTY: Lincoln
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Troy
Length of stay in 1b: 1Mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Troy Nursing Home
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Lincoln
c. CITY OR TOWN:
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 5 Mi. West of Troy
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First / Middle / Last: ADA BELL VANCLEVE
4. DATE OF DEATH: Month / Day / Year: April 6 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: Dec. 20, 1883
9. AGE (last birthday): 77
IF UNDER 1 YEAR: Months 3 Days 16
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (City and state or country): St Louis Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Wm. C. Mitchell
13b. MOTHER'S MAIDEN NAME: Mary Henderson
14. NAME OF HUSBAND OR WIFE: Joseph G Vancleve
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs Henry James Address: Troy MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION / COUNTY / STATE

21. I attended the deceased from Feb. 7, to April 6, 1961 and last saw her/him alive on Apr. 6 1961
Death occurred at 10.05P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): H. F. Kelley D.O.
22b. ADDRESS: Troy Mo.
22c. DATE SIGNED: Apr. 7, 61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: April 10, 1961
23c. NAME OF CEMETERY OR CREMATORY: Oak Grove Cemetery
23d. LOCATION (City, town, or county) (State): St Charles Mo.

24. FUNERAL DIRECTOR: D.W. McCoy ADDRESS: Troy Mo
25. DATE RECD. BY LOCAL REG.: 4-7-1961
26. REGISTRAR'S SIGNATURE: Charlotte Leek

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED
BY AFFIDAVIT OF DOCUMENT

APR 18 1961

APR 27 1961

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 D. W. McCoy

Licensed Embalmer No. 3586

P. O. Address Troy 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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