

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

26710

1. PLACE OF DEATH

County Cassell
Township Cassell
City Cassell (No.)

Registration District No. 135
Primary Registration District No. 3010

File No.
Registered No. 78 (Ward)

2. FULL NAME

Jeannette Winfrey
(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-22-1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
2 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Cassell Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Cecil C. Winfrey

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Cassell Co. Mo

12. MAIDEN NAME OF MOTHER Minnie Helms

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Cassell Co. Mo.

14. INFORMANT Mrs Cecil C. Winfrey
(Address) Cassell Mo.

15. FILED 9-17-27 Mrs E. E. Jamham
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-17 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1927 to Sept 17, 1927
that I last saw him alive on Sept 17, 1927, and that death occurred, on the date stated above, at 6:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11A
107A (duration) yrs. mos. da. 5
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.

19. DID AN OPERATION PRECEDE DEATH. 0 DATE OF

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Charles S. Austin, M. D.
9/19, 1927 (Address) Cassell Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Hill DATE OF BURIAL 9-20 1927

20. UNDERTAKER Willis Bros. ADDRESS Cassell Mo.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

When under ten years, it is necessary to state whether Broncho Pneumonia followed measles, whooping cough, or some other disease. Or was Broncho Pneumonia primary cause of death?
Please sign and return.

child delicate since birth
finally causing Broncho
Pneumonia

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Carroll

Registration District No. 135-

File No. 26710

Township Carrollton

Primary Registration District No. 3010

Registered No. 78

City Carrollton (No.) St. Ward

2. FULL NAME

(a) Residence. No. Jeannette Winfrey St. Ward

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

7

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 9-19-27 Mrs E E Farnham REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-17-27

17.

I HEREBY CERTIFY, That I attended deceased from

to, 19....., and that that I last saw h..... alive on, 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Proprio - pneumonia
flu gripe developing into Broncho Pneumonia

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

19

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.