N. B.—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.

JAN 20 1928

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

830

Do not use this space.

39180

1. PLACE OF DEATH

County: Shelby — Registration District No.: Digwood.

Township: Lentner — Primary Registration District No.: 6095

City: Lentner (No. ..., ..., St. ..., Ward)

File No.:

Registered No.:

2. FULL NAME: Mrs Virginia Wingate

(a) Residence. No. ... 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. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 16 - 1853

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
74	5	6	

8. OCCUPATION OF DEACESED

(a) Trade, profession, or particular kind of work: Housekeeper.

(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): Missouri

PARENTS

10. NAME OF FATHER: Henry Kidwell

11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Kentucky

12. MAIDEN NAME OF MOTHER: Nancy Mullins

13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Kentucky

14. INFORMANT: Mrs Ada Mefford
(Address): Lentner Mo

15. FILED ..., 19...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12 - 22 - 1927

17. I HEREBY CERTIFY, That I attended deceased from 12-20-, 1927, to 12-22-, 1927 that I last saw he alive on on 12-21-, 1927, and that death occurred, on the date stated above, at 9 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardio-vascular disease

(duration) 5 yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY)

(duration) ... yrs. ... mos. ... ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) A. M. Wood, M. D
Jan 7, 1928 (Address) Shelbina

*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 Ridge Cemetery — DATE OF BURIAL: Dec 24 1927

20. UNDERTAKER: E. E. Hopper — ADDRESS: Clarence Mo.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

~~20191~~

1. PLACE OF DEATH
County Shelby — Registration District No. 830 — File No.
Township — Primary Registration District No. 6095 — Registered No.
City Lentner (No. , St. Ward)

2. FULL NAME Virginia Wingate
(a) Residence. No. 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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)

PARENTS
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 Jan 10 1927 Madge Gooch
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-22 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19.... that I last saw h.... alive on ....., 19...., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY)

(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE OR CERTIFICATES UNTIL THE ARE ... PRESCRIBED BY LAW