

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33085

Registration District No. 567

Primary Registration District No. 6903

Registrar's No. 67

1. PLACE OF DEATH: *New Madrid*
(a) County *New Madrid*
(b) City or town *Rural*
(c) Name of hospital or institution: *(If outside city or town limits, write "RURAL" and name of township)*

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days) *1 mo* *5 3/4*

3. (a) PRINT FULL NAME *HAROLD JEAN WINDERS*

3. (b) If veteran, name war 3. (c) Social Security No. *_____*

4. Sex *Male* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *_____*

6. (b) Name of husband or wife *_____* 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased *Aug 7, 1939*
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 6 hr. min.

9. Birthplace *New Madrid Co. Mo.*
(City, town, or county) (State or foreign country)

10. Usual occupation *_____*

11. Industry or business *Electric Winders*

12. Name *Clotus Winders*

13. Birthplace *New Madrid Co. Mo.*
(City, town, or county) (State or foreign country)

14. Maiden name *Mary E. Churn*

15. Birthplace *Alabama*
(City, town, or county) (State or foreign country)

16. (a) Informant's signature *Clotus Winders*
(b) Address *East Prairie, Mo.*

17. (a) *Rural* (b) Date thereof *Sept 14 39*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Dogwood*

18. (a) Signature of funeral director *Davis N. Shelby*
(b) Address *East Prairie, Mo.*
19. (a) *9-27-39* (b) *Wm. H. Hodges*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State *Missouri* (b) County *New Madrid*
(c) City or town *Rural*
(If outside city or town limits, write "RURAL")

(d) Street No. *7 miles South West of East Prairie*
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Sept* day *13*
year *1939* hour *10* minute *20* A. M.

21. I hereby certify that I attended the deceased from *Sept 9*, 1939 to *Sept 13* 1939
that I last saw him alive on *Sept 13* 1939
and that death occurred on the date and hour stated above.

Immediate cause of death *Gastro Enteritis*

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) *114*

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature *A. J. Martin* (M. D. or other) _____

Address *East Prairie* Date signed *Oct 6*

PHYSICIAN
Underline the cause to which death should be charged statistically.

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.

08)

RECEIVED

District Health Officer No. 2,

District File Number 1039-282

Date Filed 10-13

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

....., Registered Apprentice No. 2726
working under my personal supervision.

Signed Travis Shelby

Licensed Embalmer No.

P. O. Address East Plain

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, above space should be left blank.