

Registration District No.

Primary Registration District No.

1001

FILED JUN 10 1940

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

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town Saint Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2318 Angelique St.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2
(Specify whether
 In this community About 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
 (c) City or town Saint Joseph, MO.
(If outside city or town limits, write "RURAL")
 (d) Street No. 2318 Angelique
(If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME

Winnie Scott 307

8. (b) If veteran, name war _____

3. (c) Social Security No. +

4. Sex Female 5. Color or race Negro

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Charles

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased 10, 15,
(Month) (Day) (Year)

1860

8. AGE: Years 79 Months 6 Days 20 hr. _____ min. 0
If less than one day

9. Birthplace Plattsburg MO.
(City, town, or county) (State or foreign country)

10. Usual occupation House Keeper

11. Industry or business " " 9

12. Name Andrew Bassett 9

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Sadie Scott

(b) Address 2318 Angelique

17. (a) Removal (b) Date thereof 5/8/1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Plattsburg MO.

18. (a) Signature of funeral director Ramsay & son Mortuary

(b) Address 1602 Messanie Street

19. (a) 5/8/40 (b) H. J. Prestleburgh
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 5th, day 5, 1940.
 year 1940 hour 1:40 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from March 15-1940
 to May 5, 1940

that I last saw her alive on May 5, 1940

and that death occurred on the date and hour stated above.

Immediate cause of death General Paralysis

Due to General Paralysis and Anemia

Due to as above stated

Other conditions _____

Major findings: none

Of operations _____

Of autopsy none

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?
85

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature H. J. Prestleburgh (M. D. or other) _____

Address 720 S. 24th St. St. Joseph, Mo. Date signed 5-8-40

Duration March 15-40 to May 6-40
 PHYSICIAN _____
 Underlines the cause to which death should be charged statistically.

82A

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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed J. F. Ramsey

Licensed Embalmer No. 4081

P. O. Address Joseph 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17879
Registrar's No. 220

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 85-

Primary Registration District No. 1001

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

1. PLACE OF DEATH:

(a) County Ozark
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Winnie Deett

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race Black

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased

(Month) (Day) (Year)

8. AGE:

Years 79 Months 6 Days 20

If less than one day _____ hr _____ min

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(b) Date thereof

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) July 18, 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the _____ date and hour stated above.

Immediate cause of death General and an
emia as above stated

Due to _____

Due to Acute secondary

Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy none

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

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 _____

Signature R. A. Crossland (Physician)
Address St Joseph, Mo Date signed _____

SUPPLEMENTARY

S-17879