

No. 2
-10-20
7-3
X218

Registration District No. 466

Primary Registration District No. 3024

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Lexington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 19th main
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 wks. (Specify whether years, months or days)

8. (a) PRINT FULL NAME Jennie E Wikoff 210
8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Cyrus Franklin Wikoff 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Nov. 19 1859
(Month) (Day) (Year)

8. AGE: Years 80 Months 9 Days 0 If less than one day hr. _____ min. _____

9. Birthplace: Salem Ill
(City, town, or county) (State or foreign country)

10. Usual occupation: at home

11. Industry or business _____
MOTHER FATHER { 12. Name Henry Bascom
13. Birthplace Adams, Co. Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Ada McColin
15. Birthplace not known
(City, town, or county) (State or foreign country)

16. (a) Informant L. B. Wikoff
(b) Address Lexington, Mo

17. (a) Burial (b) Date thereof Aug 20 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chillicothe, Mo

18. (a) Signature of funeral director Winkles
(b) Address Lexington, Mo

19. (a) Sept 9/40 (b) Delia Bales
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Lafayette
(c) City or town Lexington, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 19th main (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19 year 1940 hour 5 minute 30 a. M.

21. I hereby certify that I attended the deceased from Aug 16/40 to Aug 19 1940 and that death occurred on the date and hour stated above.

that I last saw h. alive on Aug 18 1940
Immediate cause of death: Cerebral Hemorrhage

Duration _____
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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? _____

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

23. Signature [Signature] (M. D. or other) _____
Address [Signature] Date signed Aug 20/40

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

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 9-11-40

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.
working under my personal supervision.

Signed Garret J. Kempel
Licensed Embalmer No. 3275
P. O. Address Livingston, 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.