

No. 2
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17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28910

State File No. 78

Registration District No. 4661

Primary Registration District No. 3024

Registrar's No. _____

1. PLACE OF DEATH: Lafayette
 (a) County Lafayette
 (b) City or town Luxington
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 221 Washington
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community Life
 years, months or days

8. (a) PRINT FULL NAME Ann Maria Winn 500
 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 James F Winn 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 23 1859
 (Month) (Day) (Year)

8. AGE: Years 81 Months 0 Days 29 If less than one day hr. _____ min. _____

9. Birthplace Dover Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____
 12. Name Dr. Samuel Thornton Mengel
 13. Birthplace Buckingham Co. Va.
 (City, town, or county) (State or foreign country)
 14. Maiden name Calmira Harrison
 15. Birthplace Columbia Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant Miss Puxton Tabb
 (b) Address Luxington Mo

17. (a) Burial (b) Date thereof Aug. 24-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Luxington Mo

18. (a) Signature of funeral director Winkler
 (b) Address Luxington Mo

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

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Lafayette
 (c) City or town Luxington Mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. 221 Washington
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 22
 year 1940 hour 5 minute 10 a. M.

21. I hereby certify that I attended the deceased from Aug 4, 1940, to Aug 22, 1940
 that I last saw h. or alive on Aug 21/40, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis

Due to _____
 Due to _____

Other condition: Arteriosclerosis & Hypertension
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations: _____
 Of autopsy: _____

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? 870

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

23. Signature Temple Bruce (M. D. or other) _____
 Address Luxington Mo Date signed 8/23/40

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 *Forest F. Tempel*
Licensed Embalmer No. *3276-*
P. O. Address *Lexington, Va.*

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.