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

FILED OCT 11 1940

31364
Do not use this space.

1. PLACE OF DEATH
(a) County Ballinger
(b) Township Wayne
(c) City Advance Mo
(d) Street No. ... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred R-4 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 69
Primary Registration District No. 5105
Registered No. 30

2. PRINT FULL NAME Lula Josephine Winkler
(a) Residence, No. Advance Mo Rt 4 St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	white	married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 3 1892

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	48		7	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ballinger Co Mo 0

FATHER
13. NAME James Turner
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark 0

MOTHER
15. MAIDEN NAME Shaba Baker
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Henry Winkler Advance Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Old Salem DATE July 10 1940

19. FUNERAL DIRECTOR (NAME) Lloyd Simpson
(ADDRESS) Advance Mo.

20. FILED 9/23 1940 Mrs. Julia Berry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 10th 1940

22. I HEREBY CERTIFY, That I attended deceased from Oct 1939 to July 10th 1940
I last saw her alive on July 10th 1940. Death is said to have occurred on the date stated above, at 8 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of Rectum and Sigmoid Colon	

Other contributory causes of importance:

Name of operation ... Date of ...
What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...
Where did injury occur? ... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury ...
Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify ...

(Signed) E. C. Masters M. D.
(Address) Advance Mo.

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

I X14028

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, ...
Lloyd O Morgan, or by .....,

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

Signed Lloyd O Morgan

Licensed Embalmer No. 3761

P. O. Address Adrian 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.

No. 2B
-2-21-40
I X22659

ROWENA MOORE

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31364

Registration District No. 69 — Primary Registration District No. 5708 — Registrar's No.

1. PLACE OF DEATH
(a) County Ballinger
(b) ~~City or town~~ Wayne T. P.
(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 (Specify whether years, months or days)
In this community

3. (a) PRINT FULL NAME Viola Josephine Winkler
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 48 | Months - | Days 7 | 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)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received by local registrar) (b) (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.

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 10
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Carcinoma of rectum
Due to and Sigmoid colon
Primary seat in rectum 2
Due to Surgical, I did not see her until
about 1 months before death, Diagnosis
Other conditions Abdominal is of State Cancer
(Include pregnancy within 3 months of death)
Major findings: Hospital of Columbia
Of operations
Of autopsy 4/0

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

23. Signature E. C. Mastin (M. D. or other) M.D.
Address Advance Mo Date signed

No. 2B
2-21-40
I X22659

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

ROWENA MOORE

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31364

Registration District No. 69 Primary Registration District No. 5108 Registrar's No. 30

1. PLACE OF DEATH:
(a) County Bollinger
(b) City or town Marble
(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 (Specify whether years, months or days)
In this community

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.

3. (a) PRINT FULL NAME Lula Josephine Winkler
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 48 Months Days 7 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)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death Carcinoma of rectum and sigmoid colon
Duration
Due to Primary Site in Rectum
Due to
Other conditions (Include pregnancy within 3 months of death) 4 lb
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature E. C. Masters (M. D. or other) DO.
Address Advance, Mo. Date signed July 31 1940