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39
23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32605**

Registration District No. **1095**

Primary Registration District No. **3770**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County **Moniteau**
 (b) City or town **Clarksburg (Rural)**
(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 **20**
(Specify whether)
 In this community **Entire Life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Moniteau**
 (c) City or town **Clarksburg (Rural)**
(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 **Mary Estella Wingate**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife **M. L. Wingate** 6. (c) Age of husband or wife if alive **Deceased** years

7. Birth date of deceased **May 16 1868**
(Month) (Day) (Year)

| | | | |
|-------------------------|-----------------|----------------|--|
| 8. AGE: Years 72 | Months 4 | Days 13 | If less than one day hr. _____ min. _____ |
|-------------------------|-----------------|----------------|--|

9. Birthplace **Butler County Pennsylvania**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Same**

12. Name **Robert Galbreath**

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

14. Maiden name **Smith**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **R. E. Wingate**

(b) Address **Clarksburg Mo.**

17. (a) **Burial** (b) Date thereof **10-1-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sappington Cemetery**

18. (a) Signature of funeral director **James E. Richards**

(b) Address **Sappington Mo**

19. (a) **10-1** (b) **40**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **29**
year **1940** hour **5** minute **30 P.M.** M.

21. I hereby certify that I attended the deceased from **Sept 23**, 19**40** to **Sept 29**, 19**40**
that I last saw h. alive on **Sept 24**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Bronchitis**
Chronic Hepatitis **2 years**
7

Due to _____
Due to **124/80**

Other conditions **Secondary Anemia**
(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?
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(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature **E. A. Tibbs** (M. D. or other) _____

Address **California Mo** Date signed **9/30/40**

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

MOTHER FATHER

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 Jemee-E. Richardson
Licensed Embalmer No. 2466
P. O. Address Tipton, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.