No. 2
-4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26039

11 1941 District No. 761 Primary Registration District No. 4456 Registrar's No. 24

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

1. PLACE OF DEATH:
(a) County St Clair
(b) City or town Appleton City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ellett Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 52 days (Specify whether
In this community 53 yrs 5 mo 15 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Bates 7
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 7 mi west of Appleton City
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME RUTH MARIAH WIX
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex Fem
5. Color or race White
6. (a) Single, widowed, married, divorced DIVORCED
6. (b) Name of husband or wife John A Wix
6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased ~~July~~ Jan 13. 1888
(Month) (Day) (Year)

8. AGE: Years 53 Months 5 Days 15 If less than one day ___ hr. ___ min.

9. Birthplace Appleton City Mo
(City, town, or county) (State or foreign country)
10. Usual occupation House Keeping
11. Industry or business
FATHER
12. Name J. M. Varnes
13. Birthplace Warrensburg Mo
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Ollie Rains
15. Birthplace Appleton City Mo
(City, town, or county) (State or foreign country)
16. (a) Informant J. M. Varnes
(b) Address Appleton City Mo
17. (a) Burial (b) Date thereof July 12. 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oakhill Cem
18. (a) Signature of funeral director Frank Lee
(b) Address Appleton City Mo
19. (a) 7-11-41 (b) Mrs. Olie Abney
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10
year 1941 hour 4 minute 5/8 M.
21. I hereby certify that I attended the deceased from May 19, 1941, to July 10, 1941;
that I last saw him alive on July 10, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of colon

Due to

Due to

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

23. Signature [signature] (M. D. or other) [signature]
Address Appleton City Mo Date signed 7-11-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 8-41-1266
Date Filed 8-7-41

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 on the 10th day of July 1941, Registered Apprentice No. ..... working under my personal supervision.

Signed Frank Lee

Licensed Embalmer No. 1099

P. O. Address Appleton Ohio

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.

S. No. 2B
M—8-21-41
I X29288

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. 26039

Registration District No. 761 Primary Registration District No. 4456 Registrar's No. 24

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County St. Clair
(b) City or town Appleton City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ellett Hospital
(If not in hospital or institution, write street address or location)
(d) Length of stay: In hospital or institution 02 days
In this community 5 yrs 6 mo 15 da (Specify whether years, months or days)

2. USUAL RESIDENCE OF DEASCED:
(a) State Mo (b) County St. Clair
(c) City or town Rural Appleton City
(If outside city or town limits, write "RURAL")
(d) Street No. 1 mi W of Appleton City
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ruth M. Wing
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 div.
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 Months Days If less than one day 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) (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) 9-20-41 (Date received local registrar) (b) Ola Abney (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 18 year 1941 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.

	Duration
Immediate cause of death	
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)
(b) 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
23. Signature (M. D. or other)
Address Date signed