No. 2

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

43267

State File No.

DEC 24 1941 318 899

Registration District No.

Primary Registration District No. 6205

Registrar's No.

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

1. PLACE OF DEATH:

(a) County ~~GREENE~~ Webster

(b) City or town ~~Springfield~~ Elkland

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Elkland MO. RFRD. One.

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether

In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster

(c) City or town Elkland

(If outside city or town limits, write "RURAL")

(d) Street No. ..... (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Mabel Clara Wingo

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex F

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ear Earl Wingo

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased June (Month) 4 (Day) 1888 (Year)

8. AGE: Years	Months	Days	If less than one day
52	1	24	..... hr. ..... min.

9. Birthplace ..... Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name Thomas E. ROland
13. Birthplace ~~Melton~~ (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Melton
15. Birthplace ..... (City, town, or county) ~~Melton~~ Mo. (State or foreign country)

16. (a) Informant Earl Wingo, Husband.

(b) Address Elkland MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29 (Month) (Day) (Year)

(c) Place: burial or cremation Olive

18. (a) Signature of funeral director W. L. Dunn.

(b) Address 629 W. Walnut Springfield, Mo.

19. (a) July 28 (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28 year 1941 hour 5 minute 30 M.

21. I hereby certify that I attended the deceased from 7 29 41 7 28 1941 to 8 28 1941; that I last saw h Dead When I arrived alive on 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cause unknown	
Due to Probly Septic Gaus	
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy No

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) No

(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 M Bailey (M. D. or other)

Address Elkland MO Date signed 7 29 41

1048

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3267

Registration District No. 899 Primary Registration District No. 6205 Registrar's No.

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Webster

(b) City or town 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 (Specify whether
In this community years, months or days)

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mabel C. Wingo

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 June (Month) 4 (Day) 1889 (Year)

8. AGE: Years 52 Months 1 Days 22 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)
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) Feb 23 1942 (Date received local registrar) J R Bruce (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28 year 1941 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 Probaly Goiter	
Due to No further information possible	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 63a

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

S-43267