

Filed NOV 12, 1942

Registration District No. _____

Primary Registration District No. 2000

Registrar's No. 724

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 8708 National
(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) 3 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 30
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL") 6
(d) Street No. 870 South National
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____ 0

3. (a) PRINT FULL NAME Ida Belle Wrinkle

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Luther Wrinkle 6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased May 23 1871
(Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Hickory Co Missouri
(City, town, & county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name William Harvey

13. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Crawford

15. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Luther Wrinkle

(b) Address Halfway

17. (a) Burial (b) Date thereof Oct 11 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nemo Cemetery

18. (a) Signature of funeral director Chas Jester of Hutchison Co

(b) Address Bolivar Mo

19. (a) 10-10-42 (b) W. B. Heston
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9
year 1942 hour 11 minute _____ P. M.

21. I hereby certify that I attended the deceased from July 28
1942, to 10-9-42, 19____

that I last saw her alive on 10-9-42, 19____

and that death occurred on the date and hour stated above.
Immediate cause of death Myocardial insufficiency

Due to carcinomatosis

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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature William Harvey (M.D. or other) _____

Address Woodruff Building Date signed 10-12-42

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

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 *Obby Jester*
Licensed Embalmer No. *4154*
P. O. Address *Bolivar 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.

X - - - 41

STANDARD CERTIFICATE OF DEATH

State File No. 33782

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 724

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(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:

In this community:
years, months or days

3. (a) PRINT FULL NAME

Ida Belle 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: May 23
(Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 20 If less than one day _____ min.

9. Birthplace: _____ (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-15-43 (b) W. J. Handley
(Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1942 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I first saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death myocardial insufficiency

Due to carcinomatosis primary seat, uterus

Due to _____

Other conditions: _____ (Include pregnancy within 9 months of death)

Major findings: _____ Of operations _____

Of autopsy _____

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. [illegible] (Date or other) _____

Address _____ Date signed 2-17

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-33782

1942