No. 2
—5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 19 1942

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36480

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4160

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: St. Lukes O (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether

In this community 1 Day years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette 54

(c) City or town Lexington 5 (If outside city or town limits, write "RURAL") 2

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

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

If yes, name country 1

3. (a) PRINT FULL NAME Wingate Infant

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. (Month) 8 (Day) 1942 (Year)

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

9. Birthplace Kansas City (City, town, or county) Mo. O (State or foreign country)

10. Usual occupation infant

11. Industry or business

FATHER
12. Name Herbert Wingate
13. Birthplace California (City, town, or county) mo O (State or foreign country)

MOTHER
14. Maiden name Alice Shelby
15. Birthplace Lexington (City, town, or county) Mo. O (State or foreign country)

16. (a) Informant Father Herbert Wingate

(b) Address Lexington Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-8-42 (Month) (Day) (Year)

(c) Place: burial or cremation Lexington Mo.

18. (a) Signature of funeral director Winkler Fur. Home

(b) Address Lexington Mo.

19. (a) 11-8-42 (Date received local registrar) (b) M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 8th year 1942 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 11/7, 1942, to 11/8, 1942 that I last saw him alive on 11/8, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Atalectasis	
Due to 161a	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy atalectasis	

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) O

Address 1101 Bryant Bldg. Cc Mo Date signed 11/8/42

(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 with 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. 36480

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4160

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas city
(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) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: Wingate Infant

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

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

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: S

6. (b) Name of husband or wife .....

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

7. Birth date of deceased: Nov (Month) 7 (Day) 1942 (Year)

8. AGE: Years | Months | Days | If less than one day: ..... hr. ..... min.

9. Birthplace: ..... (City, town, or county) MO (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) 11/8/42 (Date received local registrar) (b) M. M. Grove (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... year ..... 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.

Immediate cause of death	Duration
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? ..... (Specify type of place)

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

23. Signature ..... (M. D. or other) .....

Address ..... Date signed .....

S-36480 1942