

MAR 8 1943

10

3002

Registration District No. ....

Primary Registration District No. ....

1. PLACE OF DEATH:

(a) County Audrain  
(b) City or town Mexico  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Audrain Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days (Specify whether  
In this community Life (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain  
(c) City or town Mexico  
(If outside city or town limits, write "RURAL")  
(d) Street No. 822 E. Monroe  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME Carol Jean Windsor

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

4. Sex F / race W 5. Color or  
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 Aug. 21, 1942  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
--- 6 4 hr. min.

9. Birthplace Mexico, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Baby

11. Industry or business

12. Name Lester Windsor

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

14. Maiden name Mary Brock

15. Birthplace Princeton, Kansas (City, town, or county) (State or foreign country)

16. (a) Informant Lester Windsor

(b) Address Mexico, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/43 (Month) (Day) (Year)

(c) Place: burial or cremation Williamsburg, Mo.

18. (a) Signature of funeral director Alvin A. ...

(b) Address Mexico, Missouri

19. (a) 2/25/43 (Date received local registrar) (b) Margaret H. Mackie (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 25  
year 1943 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from 9-22-42 to 9-25-42  
that I last saw him alive on 9-25-42 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia

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?

While at work? (Specify type of place) (e) Means of injury  
23. Signature Frank Galley (M. D. or other) D. M.D.  
Address Mexico, Mo. Date signed 2/7/43

MOTHER FATHER

10 8/27

RECEIVED

District Health Officer No. 19

District File Number 3-43-447

Date Filed MAR 8 1949

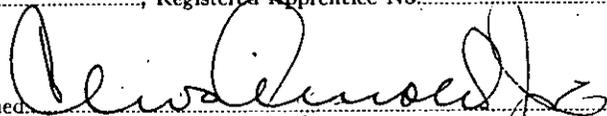
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

working under my personal supervision.

....., Registered Apprentice No. ....

Signed



Licensed Embalmer No. 3569

P. O. Address Union

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. J 705

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Andrew  
 (b) City or town Mexico  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Andrew Hosp  
 (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. (a) PRINT FULL NAME Carol Jean Windsor

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 S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 21 - 1943  
 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ if less than one day \_\_\_\_\_ min.

9. Birthplace Mo  
 (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) \_\_\_\_\_ (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Andrew  
 (c) City or town Mexico  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 823 E. Monroe  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 29 Year 1943 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to No complications

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
 (Specify type of place)  
 While at work? \_\_\_\_\_ (c) Cause of injury \_\_\_\_\_

23. Signature Dr. Frank J. Kelly (M. D. or other) \_\_\_\_\_

Address Mexico, Mo. Date signed 3/27/43

SUPPLEMENTARY

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

MOTHER FATHER

