DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 11 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

17577 State File No.

Registration District No. 5-8 Primary Registration District No. 5216 Registrar's No. 14

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:
(a) County Carter
(b) City or town Freemont 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) 15 years

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

3. (a) PRINT FULL NAME WINNIE ANN CONWAY
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, 2, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug (Month) 11 (Day) 1866 (Year)

8. AGE: Years 77 Months 9 Days 21 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation house wife
11. Industry or business
FATHER 12. Name Franklin Woods
FATHER 13. Birthplace (City, town, or county) U.S.A. / (State or foreign country)
MOTHER 14. Maiden name Martha Williams
MOTHER 15. Birthplace (City, town, or county) U.S.A. / (State or foreign country)
16. (a) Informant's own signature Ben Conway
(b) Address Freemont Mo
17. (a) (Burial, cremation, or removal) (b) Date thereof 5-6-1943 (Month) (Day) (Year)
(c) Place: burial or cremation Bethel Chapel
18. (a) Signature of funeral director Seaton Pewitt
(b) Address Van Buren Mo
19. (a) May 3 1943 (Date received local registrar) (b) Mrs A J Smith (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 2
year 1943 hour 4 minute 30A. M.

21. I hereby certify that I attended the deceased from 5-3 1943, to 4-10 1943, that I last saw her alive on 4-10 1943, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death myocardial degeneration	15 yr.
Due to arterial hypertension	10 yr.
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 93d.	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Frank J. Rusinski (M. D. or other) DO
Address Van Buren, Mo. Date signed 5-3-43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No 5,
District File Number 643367
Date Filed 6-8-43

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.

This Body was not embalmed

Signed Seaton Pruett

Licensed Embalmer No. 2287

P. O. Address Van Buren

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, above space should be left blank.

S. No. 2B
DM—5-43
o I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17577

Registration District No. 58 Primary Registration District No. 5216 Registrar's No. 14

1. PLACE OF DEATH:
(a) County Carter
(b) City or town Rural Pike Twp
(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 Winnie A. Conway
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 (Month) Aug (Day) 11 (Year)

8. AGE: Years 44 | Months 8 | Days | If less than one day hrs. 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) May 3 1943 (Date received local registrar) (b) Mrs A J Smith (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May year 1943 hour minute M.

21. I hereby certify that I attended the deceased from ..., 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	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY