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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED APR 5 1943

Registration District No. 218

Primary Registration District No. 3017

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Howard Cooper  
(b) City or town Boonville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Van Ravensway Clinic  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 39-days (Specify whether  
in this community 39-days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone  
(c) City or town Hallsville  
(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 1

3. (a) PRINT FULL NAME CYRENA BIRDIE WINDSOR

3. (b) If veteran, name war None 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 E.R. Windsor 6. (c) Age of husband or wife if alive 39 years  
7. Birth date of deceased 11 - 1 - 1879  
(Month) (Day) (Year)

8. AGE: Years 63 Months 4 Days 7 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name S.P. Kemper  
13. Birthplace Boone County Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Susan F. Warnock  
15. Birthplace Boone County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant S.P. Kemper  
(b) Address Hallsville, Mo.

17. (a) Burial (b) Date thereof 3-10-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Friendship Cem.

18. (a) Signature of funeral director James - Keeney  
(b) Address Boonville, Mo.

19. (a) May-10-43 (b) Dr. Chas. Swap  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8  
year 1943 hour 1:30 minute P. M.

21. I hereby certify that I attended the deceased from JAN 27,  
1943 to 3-8, 1943.  
that I last saw her alive on 3-8 and that death occurred on the date and hour stated above.

Immediate cause of death Cirrhosis of Liver & acute

Due to .....  
Due to .....  
Other conditions (Include pregnancy within 3 months of death) 1248

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) (e) Means of injury .....

23. Signature Hubert D. Wells (M. D. or other) Boonville, Mo.  
Address Boonville, Mo. Date signed 3-10-43

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

1088

(Licensed Embalmer's Statement on Reverse Side)

Health Officer No. 8,

District File Number.....

Date Filed 4-2-43

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**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 W. W. Whitfield  
Licensed Embalmer No. 3893  
P. O. Address Columbia, Md.

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 218

Primary Registration District No. 3017

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Cooper  
(b) City or town Boonville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Don Rauhenshaw Clinic Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 39 days  
(Specify whether In this community 39 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone  
(c) City or town Hallsville  
(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

Ayresia Biederwieser

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 W

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

7. Birth date of deceased mo. (Month) (Day) (Year)

8. AGE: Years 63 Months 4 Days 14 If less than one day min.

9. Birthplace mo. (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May year 1943 hour 8 minute 5 M.

21. I hereby certify that I attended the deceased from ..... 19..... that I have seen him/her live 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)  
(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 ..... (M. D. or other) .....  
Address ..... Date signed .....

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

SUPPLEMENTARY

JAN 6 1944

JAN 4 1944

S-21204