

FILED MAY 8 1944

Registration District No. 780

Primary Registration District No. 5-392

Registrar's No. 28

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

1. PLACE OF DEATH:

(a) County Dent

(b) City or town Lecoma Mo., Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Waltham Camp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 26 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent

(c) City or town Rural... Lecoma, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Thomas O. Wynn

3. (b) If veteran, name war 0

3. (c) Social Security No. 0

4. Sex Male

5. Color or race Wh.

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

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

6. (c) Age of husband or wife if alive 0 years

7. Birth date of deceased August 20, 1857
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>86</u>	<u>7</u>	<u>5</u>	<u>0</u> hr. <u>0</u> min.

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

10. Usual occupation Farmer

11. Industry or business 0

MOTHER FATHER

12. Name Dont

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

14. Maiden name Dont

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

16. (a) Informant Mrs. Gerald Treat

(b) Address Lecoma, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-44 (Month) (Day) (Year)

(c) Place: burial or cremation Lake Springs Mo.,

18. (a) Signature of funeral director Null & Son

(b) Address Rolla, Missouri

19. (a) 4-6-44 (Date received local registrar) (b) J. D. McLeary (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25
1944 year 4 hour 4 minute 55 A. M.

21. I hereby certify that I attended the deceased from mar 23, 1944, to mar 25, 1944 that I last saw him alive on mar 23, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage

Duration 2 days

Due to 0

Due to 0

Other conditions 0
(Include pregnancy within 3 months of death)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations 0

Of autopsy 0

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 0

(b) Date of occurrence 0

(c) Where did injury occur? (City or town) (County) (State) 0

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0

While at work? (Specify type of place) (e) Means of injury 0

23. Signature E. G. F. ... (M. D. or other) 0

Address Rolla Mo Date signed 3-25-44

RECEIVED

District Health Officer No. 5,

District File Number 444264

Date Filed 8-6-44

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

S. L. [Signature]

Licensed Embalmer No. 3324

P. O. Address Rolla, mo

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.