. No. 2
1—2-43
5-17-39
I X38597

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

FILED SEP 8 1945

DEPARTMENT OF COMMERCE
BUREAU OF CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27463

Registration District No. 137 | Primary Registration District No. ~~3035~~ 4218 | Registrar's No. 165

1. PLACE OF DEATH:
(a) County: Henry
(b) City or town: Windsor, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Community Rest Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 weeks (Specify whether years, months or days)
In this community 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Benton 8
(c) City or town: Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No.: Rt#2, West White Township c
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Alba Arthur Andrews
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: M 0
5. Color or race: W
6. (a) Single, widowed, married, divorced: M 1
6. (b) Name of husband or wife: Mildred LaHue
6. (c) Age of husband or wife if alive: 57 years
7. Birth date of deceased: August 23, 1883 (Month) (Day) (Year)

8. AGE: Years 61 | Months 11 | Days 0 | If less than one day ___ hr. ___ min.

9. Birthplace: Rockville, Missouri 0 (City, town, or county) (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business: Farming
FATHER
12. Name: Charles Andrews
13. Birthplace: Indiana 1 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Mary Ann Robertson
15. Birthplace: Illinois 1 (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. A.A.Andrews
(b) Address: Windsor, Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof: July 27, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Windsor, Mo.
18. (a) Signature of funeral director: Huston-Turner
(b) Address: Windsor, Mo.
19. (a) Aug 23rd (Date received by local registrar) (b) Myrtle Brown Lee (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23 year 1945 hour 2 minute Op. M.
21. I hereby certify that I attended the deceased from Feb 4, 1944, to July 2, 1945; that I last saw him alive on July 2, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocardial failure	
Due to Mitral Stenosis	
Due to Nephritis	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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
Signature: Geo. W. Windsor (M. D. or other) DO
Address: Windsor, Mo. Date signed 8-21-45

(Licensed Embalmer's Statement on Reverse Side)

District Health Officer No.
District File Number 8-45-898
Date Filed 9-6-45

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 [illegible]

Licensed Embalmer No. 3391

P. O. Address Windsor, 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.

. No. 2B
M—3-45
I X43880

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. Sept 16

Registration District No. 037 Primary Registration District No. 4218 Registrar's No.

1. PLACE OF DEATH:

(a) County Henry

(b) City or town Windsor
(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 Alba A. Andrews

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 23 (Day) (Year)

8. AGE: Years 61 Months 4 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 23 year 1943 hour 4 minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to Chronic nephritis	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 31
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-27463