

No. 2  
-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34178

FILED OCT 18 1945

State File No. \_\_\_\_\_

Registration District No. 200

Primary Registration District No. 3041

Registrar's No. 98

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Macon  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

(c) City or town Macon 3  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) 2

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

3. (a) PRINT FULL NAME FINIS W. WINN

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12  
year 1945 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 10, 1945 to June 12, 1945,  
that I last saw him alive on June 12, 1945,  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

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

7. Birth date of deceased: May 1 1901  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Acute Myocarditis

Due to Diabetes Mellitus X

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

8. AGE: Years 44 Months 1 Days 11  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Arden Mo. 11  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Kirk Winn

13. Birthplace Dawson County Mo. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Jessie Maggard

15. Birthplace Jacksonville Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Earl Mc See

(b) Address Macon, Mo

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof June 14 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director Albert Skinner

(b) Address Macon, Mo

19. (a) 9/19/45 (b) Gora B. Funkler  
(Date received local registrar) (Registrar's signature)

23. Signature R. D. Haddock (M. D. or other) 9/14/45  
Address Macon, Mo Date signed 9/14/45

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

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

1031

RECEIVED

District Health Officer No. 10  
District File Number 10-45-1579  
Date Filed OCT. 17 1945

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..... *Albert Skinner* .....

Licensed Embalmer No..... 757 .....

P. O. Address.....

**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.**