

No. 7
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12237**

FILED MAY 8 1946
Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **475**

1. PLACE OF DEATH:

(a) County **BUCHANAN**
(b) City or town **ST. JOSEPH**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
MISSOURI METHODIST 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 DAYS** (Specify whether years, months or days)
In this community **6 DAYS**

2. USUAL RESIDENCE OF DECEASED:

(a) State **KANSAS** (b) County **DONIPHAN 999**
(c) City or town **DENTON RURAL 14**
(If outside city or town limits, write "RURAL")
(d) Street No. **R.F.D. NO. 1 0**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) **2**
If yes, name country.

3. (a) PRINT FULL NAME **EDNA MYRTLE FENTON**

3. (b) If veteran, name war **----** 3. (c) Social Security No. **----**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **ARTHUR WILLIAM FENTON** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **JAN. 24, 1880**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	66	2	27	hr. min.

9. Birthplace **DONIPHAN CO. KANSAS**
(City, town, or county) (State or foreign country)

10. Usual occupation **AT HOME**

11. Industry or business

12. Name **JOHN HOOVER WYNKOOP**

13. Birthplace **LA PORTE, IND.**
(City, town, or county) (State or foreign country)

14. Maiden name **NANCY ROBERTSON**

15. Birthplace **BUCHANAN CO. MO. 0**
(City, town, or county) (State or foreign country)

16. (a) Informant **ARTHUR W. FENTON**
(b) Address **DENTON, KANSAS**

17. (a) **REMOVAL** (b) Date thereof **4-21-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **DENTON, KANSAS**

18. (a) Signature of funeral director **Wm. Clayton**
(b) Address **Denton, Kansas**

19. (a) **Apr. 25, 1946** (b) **S. J. Muthershead**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **APRIL 21** day **21**
year **1946** hour **2** minute **15 P.M.**
21. I hereby certify that I attended the deceased from **2 months**
7-11-25, 19**45**, to **4-21**, 19**46**;
that I last saw her alive on **4-20**, 19**46**;
and that death occurred on the date and hour stated above.

Immediate cause of death
Metastatic Carcinoma of the liver
Due to **Carcinoma of the Breast**
Duration **4 months**
1 1/2 years

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?
(Specify type of place) (e) Means of injury

23. Signature **J. S. Muthershead** (M. D. or other)
Address **Denton Kansas** Date signed **4-22-46**

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

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..... *Wm S. Stanton Jr.*

Licensed Embalmer No. *3778*

P. O. Address..... *Albion, Kan*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. MayRegistration District No. 4-3Primary Registration District No. 1000Registrar's No. 4758

1. PLACE OF DEATH:

(a) County Buckeman
 (b) City or town St. Joseph
 (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)

3. (a) PRINT FULL NAME

Edna M. Frenton3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex F 5. Color or race W 6. (a) Single, widowed, married,
divorced SN6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased: Jan 24
(Month) (Day) (Year)8. AGE: Years 66 Months 2 Days 4 (If less than one day
hr. _____ min. _____)9. Birthplace Kansas
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April
year 1946 hour _____ minute _____ M. _____21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to Carcinoma of the
RT Breast.

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 sta-
tistically.

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 Walter Reed MD (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

11/46

12237