

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED JUL 12 1946 STANDARD CERTIFICATE OF DEATH

State File No. **19478**
Registrar's No. **8**

Registration District No. **33** Primary Registration District No. **4044**

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

1. PLACE OF DEATH: *Boone*
(a) County *Boone*
(b) City or town *Sturgeon*
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community *entire life*
years, months or days

2. USUAL RESIDENCE OF DECEASED: *Boone*
(a) State *Mo* (b) County *Boone*
(c) City or town *Sturgeon* (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 _____

3. (a) PRINT FULL NAME: *Elsie WINN*
3. (b) If veteran, name war _____ 3. (c) Social Security No. *✓*

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month *June* day *7th*
year *1946* hour *12:30* minute _____ A.M.
21. I hereby certify that I attended the deceased from *May - 28*
1946 to *June 7* 19*46*
that I last saw her alive on *June 6* 19*46*
and that death occurred on the date and hour stated above.

4. Sex *Fe3* 5. Color or race *BLACK* 6. (a) Single, widowed, married, divorced *Widowed*
6. (b) Name of husband or wife *BENJAMIN WINN* 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased *MAY 27 1862*
(Month) (Day) (Year)

Immediate cause of death:
Very like stroke
affecting right side
Due to *Old age, some debility*
& Enemic condition
Due to _____

8. AGE: Years *84* Months *0* Days *11* If less than one day _____ hr. _____ min.

Other conditions (Include pregnancy within 3 months of death) *✓*

9. Birthplace *Mo*
(City, town, or county) (State or foreign country)
10. Usual occupation *Housewife*
11. Industry or business _____
12. Name *Joseph Ritchie*
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name *Milla Stevens*
15. Birthplace _____ (City, town, or county) (State or foreign country)

PHYSICIAN
Major findings: *✓*
Of operations _____
Of autopsy *✓* *GIS*

16. (a) Informant *Milla Sheep*
(b) Address *Sturgeon Mo*
17. (a) *Burial* (b) Date thereof *6-8-1946*
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation *Sturgeon*
18. (a) Signature of funeral director *Clarence W. ...*
(b) Address _____
19. (a) *June 8-46* (b) *Thelma ...*
(Date received local registrar) (Registrar's signature)

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 *W. H. ...* (M. D. or other) *0*
Address *Sturgeon Mo* Date signed *6-8-46*

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed.....

7-11-46

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.....

Louis E. Hopper

Licensed Embalmer No.....

4261

P. O. Address.....

Clarence M. Hopper

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.