

**FILED OCT 7 1946**  
Registration District No. **177**

Primary Registration District No. **3040**

Registrar's No. **108**

**1. PLACE OF DEATH:**

(a) County **Livingston**  
(b) City or town **Chillicothe mo.**  
(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 **Life** years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **MO** (b) County **Livingston**  
(c) City or town **Chillicothe mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **919 Calhoun**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Sept 9** day  
year **1946** hour **6** minute **40 P.M.**  
21. I hereby certify that I attended the deceased from **July 1944** to **Sept 9, 1946**  
that I last saw her alive on **Sept 7, 1946** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary occlusion** Duration **3 weeks**  
Due to **unknown**

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations **AKA**  
Of autopsy \_\_\_\_\_  
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?

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature **E. H. [unclear]** (M. D. or other)  
Address **Chillicothe mo** Date signed **9-10-46**

3. (a) PRINT FULL NAME **Emma Wynn**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** Color or race **White**  
5. Color or race **White**  
6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **John E. Wynn**  
6. (c) Age of husband or wife if alive **70** years  
7. Birth date of deceased **July 4 1879** (Month) (Day) (Year)

8. AGE: Years **67** Months **2** Days **5** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Chillicothe mo** (City, town, or county) (State or foreign country)

10. Usual occupation **house wife**

11. Industry or business \_\_\_\_\_  
12. Name **Layton Purcell**  
13. Birthplace **Dont Know** (City, town, or county) (State or foreign country)  
14. Maiden name **Matalda Willard** (City, town, or county) (State or foreign country)  
15. Birthplace **Dont Know** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. R. E. Stepp**  
(b) Address **1304 Jackson**  
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9-12-46** (Month) (Day) (Year)  
(c) Place: burial or cremation **Edgewood**

18. (a) Signature of funeral director **E. H. [unclear] 3227**  
(b) Address **Chillicothe mo**  
19. (a) **9-10-46** (Date received local registrar) (b) **Francis B. Neill** (Registrar's signature)

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

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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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.....

*Was Embalmed*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*E. Beckwith*

Licensed Embalmer No. *3227*

P. O. Address *Chillicothe, 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.**