

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **14514**

FILED APR 23 1947

Registration District No. **2**

Primary Registration District No. **5935**

Registrar's No. **136**

1. PLACE OF DEATH:

(a) County **Pettis**  
 (b) City or town **Sedalia Rural**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**R.F.D. #4**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
 In this community **2 yrs.** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Charles M. Wingfield**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **widowed**  
 6. (b) Name of husband or wife **Katharine** 6. (c) Age of husband or wife if alive..... years  
 7. Birth date of deceased **Sept 23 1862**  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**84 6 15** hr. min.

9. Birthplace **Marshall Missouri**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business

MOTHER FATHER { 12. Name **Austin Wingfield**  
 13. Birthplace **W. Va.**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **Kitty Williams**  
 15. Birthplace **W. Va.**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **Herbert Wingfield**  
 (b) Address **Sedalia R.F.D. #4**  
 17. (a) **Burial** (b) Date thereof **4-9-1947**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Herndon Hazel Grove Cem**

18. (a) Signature of funeral director **M. C. Laughlin Bros**  
 (b) Address **Sedalia**

19. (a) **4-9-47** (b) **Betty Yeager**  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Pettis**  
 (c) City or town **Sedalia**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **R.F.D. #4** (If rural, give location)  
 (e) Citizen of foreign country? **no** (Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **8**  
 year **1947** hour **1:30** minute **9** M.

21. I hereby certify that I attended the deceased from **Aug. 5**, 1946, to **April 8**, 1947;  
 that I last saw him alive on **4/7**, 1947;  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Serum**

Due to.....  
 Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **162**  
 Of autopsy.....

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 **2**

23. Signature **W. T. L. Holden** (M.D. or other) **D.O.**  
 Address **115 E. 1st St. Sedalia Mo.** Date signed **4/8/47**

(Licensed Embalmer's Statement on Reverse Side)

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

251

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 4-22-47

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.....

Licensed Embalmer No.....

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.**