

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14570

FILED APR 28 1947

Registration District No. 2947

Primary Registration District No. 4427

Registrar's No. 48

1. PLACE OF DEATH:

(a) County Pike
 (b) City or town Warrensburg
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Warrensburg General
(If not a hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 days
(Specify whether)
 In this community 20 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Deer 33
 (c) City or town Salem
(If outside city or town limits, write "RURAL")
 (d) Street No. 1
(If rural, give location)
 (e) Citizen of foreign country? 1
(Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Willard D. Gwin

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

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced Widowed
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Jan 22 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>3</u>		hr. _____ min.

9. Birthplace Washington Texas
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER, FATHER {
 12. Name William W. Gwin
 13. Birthplace New Albania Ind
(City, town, or county) (State or foreign country)
 14. Maiden name Catherine Busch
 15. Birthplace Unknown Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Willard P. Gwin
 (b) Address 14th + University, New York City
 17. (a) Cremation (b) Date thereof 4 22 47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Louis, Mo.

18. (a) Signature of funeral director Carl K. Spencer
 (b) Address Salem, Missouri
 19. (a) 4/22/47 (b) Thome C. Buckhage
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
 year 1947 hour 1 minute 15 P. M.

21. I hereby certify that I attended the deceased from 4-17, 1947, to 4-22, 1947;
 that I last saw him alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure
Pneumonia

Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 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)
 (c) Means of injury 0
 23. Signature Wm R. Lytle (M. D. certifier)
 Address Warrensburg, Mo. Date signed 4/22/47

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Cremated.

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.

Registration District No. *290*

Primary Registration District No. *4727*

Registrar's No. *488*

1. PLACE OF DEATH:

(a) County *Pulaski*
 (b) City or town *Waynesville*
(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 years, months or days)

3. (a) PRINT FULL NAME *Willard D. Lewin*

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

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *wid*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased *Jan 23 1922*
(Month) (Day) (Year)

8. AGE: Years *82* Months *3* Days _____
(Unless than one day hr. min.)

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

10. Usual occupation _____

11. Industry or business _____

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 *January* 22
 year *1942* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
 Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy *107*

Duration

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? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature *Wm. C. Little* (M. D. or other) _____
 Address *Waynesville Mo* Date signed *1/25/42*

SUPPLEMENTARY

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

14570