

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED APR 2 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 47Primary Registration District No. 3008Registrar's No. 94

## 1. PLACE OF DEATH:

- (a) County Galloway  
 (b) City or town Fulton  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
State Hospital No. 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 1/2 years 11 months  
 (Specify whether

In this community same  
 years, months or days3. (a) PRINT FULL NAME HESTER, WINSTEAD.

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S. D

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

7. Birth date of deceased DK  
 (Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
62. hr. min.9. Birthplace Mo. D  
 (City, town, or county) (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER {  
 12. Name .....  
 13. Birthplace DK 9  
 (City, town, or county) (State or foreign country)  
 14. Maiden name .....  
 15. Birthplace 9  
 (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records. 1(b) Address Fulton Mo.17. (a) Burial (b) Date thereof 3-24-48  
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation State Hospital Cemetery18. (a) Signature of funeral director R.P. Price(b) Address State Hospital Fulton Mo.19. (a) 3-24-1948 (b) John M. Moseley  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County Stoddard  
 (c) City or town Stoddard County farm  
 (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 .....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20.  
 year 1948 hour 9 minute P. M.21. I hereby certify that I attended the deceased from 1-3/48 19..... to 3-20/48. 19.....  
 that I last saw h. ER. alive on 3-20/48. 19.....  
 and that death occurred on the date and hour stated above.Immediate cause of death Cancer of the stomach.Contributory: Inanition.

Due to .....

Other conditions H/O B  
 (Include pregnancy within 3 months of death)Major findings: H/O B  
 Of operations .....Of autopsy E soft stool  
colitis

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? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? DWhile at work? D (Specify type of place) (e) Means of injury .....23. Signature R.P. Price (M. D. or other) M.D.Address Fulton Mo. 3/24/48  
58 P. Price N.O.

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed MAR 31 1948

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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.....  
....., 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.