

S. No. 2  
10-39  
5-17-39  
1-21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED OCT 29 1948

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

33455

State File No. \_\_\_\_\_

Registration District No. 180

Primary Registration District No. 4292

Registrar's No. 72

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

1. PLACE OF DEATH:

(a) County LINCOLN

(b) City or town WINEFIELD  
(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 \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

8. (a) PRINT FULL NAME MARY C. WALCOTT JEFFERSON

8. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race W

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife GEO WALCOTT 6. (c) Age of husband or wife if alive dead years \_\_\_\_\_

7. Birth date of deceased JULY 10 1857  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

91 3 7 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace WINEFIELD Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name JOSEPH B. Nelson

13. Birthplace GERMANY  
(City, town, or county) (State or foreign country)

14. Maiden name SARAH SCOTT

15. Birthplace KENTUCKY  
(City, town, or county) (State or foreign country)

16. (a) Informant SCOTT WALCOTT

(b) Address WINEFIELD, Mo.

17. (a) BURIAL (b) Date thereof 10-20-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Admire Cemetery

18. (a) Signature of funeral director ELSBERRY, Mo.

(b) Address \_\_\_\_\_

19. (a) 10/20/48 (b) B.C. Neunhilt  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LINCOLN

(c) City or town WINEFIELD  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 17  
year 1948 hour 10 minute 30 p.M.

21. I hereby certify that I attended the deceased from Oct. 15  
1948 to Oct 17, 1948  
that I last saw her alive on Oct 17, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia 2 days

Due to Cardiac insufficiency?

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations AS

Of autopsy \_\_\_\_\_

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 2

23. Signature Dr. H. F. Kelly (M. D. or other) PO

Address Winefield, Mo. Date signed 10-21-48

OCT 28 1948

RECEIVED  
District Health Officer

**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, above space should be left blank.**

Registration District No. 180

Primary Registration District No. 4292

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

1. PLACE OF DEATH:

(a) County Lincoln  
(b) City or town Waverly  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

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 \_\_\_\_\_

3. (a) PRINT FULL NAME

Mary C. W. Jefferson

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased July 10 1911  
(Month) (Day) (Year)

8. AGE: Years 91 Months 3 Days \_\_\_\_\_ (If less than one day, hr. min.)

9. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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 \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) P.C. Vassbit (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 19 Day 17 Year \_\_\_\_\_ Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 Infirmities of old age  
Other conditions arteriosclerosis  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Date signed \_\_\_\_\_

**SUPPLEMENTARY**

S-33453