

FILED SEP 20 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29340

BIRTH NO. _____ REG. DIST. NO. 88 PRIMARY REG. DIST. NO. 5329 Registrar's No. 30

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>CRAWFORD COUNTY</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>DENT</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL UNION</u> | | c. CITY OR TOWN <u>SALEM MO</u> | d. Is Residence within limits of city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <u>3 DAYS</u> | | e. STREET ADDRESS (If rural, give location) <u>STEEHVILLE MO RR1</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>STEEHVILLE MO RR1</u> | | | |

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|---|---------------------------|---|------------------------------------|---|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>ARNER</u> b. (Middle) <u>FARBUSON</u> c. (Last) <u>WINGFIELD</u> | | | 4. DATE OF DEATH <u>SEPT 15-55</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>3-6-1875</u> | 9. AGE (In years last birthday) <u>80</u> | IF UNDER 1 YEAR Months _____ Days _____ |

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|--|--|--|--|--|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FRAMER.</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>DENT COUNTY MO</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>JOSEPH WINGFIELD</u> | | 13b. MOTHER'S MAIDEN NAME <u>MARYANN GIBBS</u> | | 14. NAME OF HUSBAND OR WIFE DECEASED <u>ELIZABETH WINGFIELD</u> | | | |

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|---|--|-------------------------------------|--|--|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>MILDRED F. FREEMAN-STEELVILLE</u> ADDRESS _____ | | | |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial failure</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility</u> | | | | <u>1 year</u> | |
| | | DUE TO (c) _____ | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension, mild.</u> | | | | | |

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|------------------------------|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION <u>H44X</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
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|--|--|--|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____ | |
|--|--|--|--|---|--|

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|---|--|--|--|--|----------------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? _____ | |
|---|--|--|--|--|----------------------------------|--|

22. I hereby certify that I attended the deceased from May 3, 1955, to Sept 15, 1955, that I last saw the deceased alive on Sept 15, 1955, and that death occurred at 6:25 AM., from the causes and on the date stated above.

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|---|--|---------------------------------------|--|---------------------------------|--|
| 23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____ | | 23b. ADDRESS <u>202 Steelville MO</u> | | 23c. DATE SIGNED <u>9/15/55</u> | |
|---|--|---------------------------------------|--|---------------------------------|--|

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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24b. DATE <u>9-18-55</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>CEDAR GROVE</u> | | 24d. LOCATION (City, town, or county) (State) <u>SALEM MO</u> | |
|---|--|--------------------------|--|---|--|---|--|

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|---|--|--|--|---|--|
| DATE REC'D BY LOCAL REG. <u>9/17/55</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 505 FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS _____ | |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 277

P. O. Address Salem

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.