

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED FEB 3

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1857  
Do not use this space.

1. PLACE OF DEATH  
(a) County Callaway 1940 Registration District No. 104  
(b) Township Fulton Primary Registration District No. 3008 Registered No. 13  
(c) City Fulton (d) Street No. State Hospital # 1 St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred 2 yrs. 2 mos. 15 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MARIETTA WINSLOW  
(a) Residence, No. 729 East Elm St.  Jefferson City, Mo.  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wylie Winslow  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 37? D.K. D.K.  
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Little Rock Arkansas  
FATHER 13. NAME D.K.  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.K.  
MOTHER 15. MAIDEN NAME Lefie Hills  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Little Rock Arkansas  
17. INFORMANT (ADDRESS) Hospital Records - Fulton, Mo  
18. BURIAL, CREMATION, OR REMOVAL PLACE city cem. DATE 1/23/40  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Turner Service Jefferson City Mo.  
20. FILED Jan 20 H. R. N. Adams Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 20 1940  
22. I HEREBY CERTIFY, that I attended deceased from Feb. 15 1934 to Jan. 20 1940  
I last saw h. alive on Jan. 20 1940. Death is said to have occurred on the date stated above, at 3:20 p. m.  
The principal cause of death and related causes of importance were as follows:  
Sudden Death while undergoing operation  
Date of onset 1/20/40  
Other contributory causes of importance: None  
Name of operation Fusion Lumber Girdles Date of 1/20/40  
What test confirmed diagnosis? None Was there an autopsy? None  
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? NO Date of injury None, 1940  
Where did injury occur? None (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury None  
Nature of injury None  
24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify None  
(Signed) Lutherine Shirley M. D.  
(Address) State Hosp # 1, Fulton, Mo.

**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.....

*A. M. Davis*

....., Registered Apprentice No.....

working under my personal supervision.

Signed

*A. M. Davis*

Licensed Embalmer No.

*2741*

P. O. Address

*Jefferson City*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1857-

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. ....

Primary Registration District No. ....

Registrar's No. ....

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

1. PLACE OF DEATH:  
(a) County Callaway  
(b) City or town Fulton  
(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 \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Marietta Wenslow  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race A  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased (Month) (Day) (Year)  
8. AGE: Years Months Days If less than one day  
37 hr. min.

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

20. DATE OF DEATH: Month Jan. day 20 = 4.0  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ 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  
Sudden death  
undergoing operation  
for Wedging of 3rd vertebra due to fall  
fusion Lumbosacral spine

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

Major findings: as above.  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) accident  
(b) Date of occurrence 12/20/39

(c) Where did injury occur? Fulton, mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
State Hosp. no 1

While at work? no (Specify type of place)  
4th story trying to reach (e) Means of injury

23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

