No. 2
-1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILLED OCT 24 1941

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 31996

Registration District No. 528 Primary Registration District No. 4314 Registrar's No.

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

**1. PLACE OF DEATH:**

(a) County MACON

(b) City or town CALLAO "RURAL"
(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)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County MACON 61

(c) City or town CALLAO "RURAL" 0
(If outside city or town limits, write "RURAL")

(d) Street No. — 0
(If rural, give location)

(e) Citizen of foreign country? — 0 (Yes or No)

If yes, name country —

3. (a) PRINT FULL NAME W. L. WAINSCOTT

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ELIZABETH WAINSCOTT

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased MARCH (Month) 11 (Day) 1866 (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 5 | 3 | — hr. — min. |

9. Birthplace MACON COUNTY (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation FARMER

11. Industry or business FARMING

FATHER
12. Name E. M. WAINSCOTT
13. Birthplace K. (City, town, or county) KENTUCKY (State or foreign country)

MOTHER
14. Maiden name RACHAEL SIMPSON
15. Birthplace CHARITON COUNTY (City, town, or county) MISSOURI (State or foreign country)

16. (a) Informant Mrs. W. L. Wainscott

(b) Address Callao, Missouri

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-15-41 (Month) (Day) (Year)

(c) Place: burial or cremation CHARITON CHURCH CEMETARY

18. (a) Signature of funeral director H. E. Edwards

(b) Address Bevier Mo

19. (a) 9/20-1941 (Date received local registrar) (b) H. L. Baker (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 14th year 1941 hour 9 minute A M.

21. I hereby certify that I attended the deceased from 8/19/41, 19__, to Sept 13, 1941; that I last saw him alive on Sept. 13, 41, 19__; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Chronic Myocardial Disease | 2 yrs |
| Due to Hypertensive Heart Disease | 10 yrs |
| Due to Chronic Interstitial Nephritis | ? |
| Other conditions: Lung Abscess (Include pregnancy within 3 months of death) | 14 days |

Major findings:
Of operations
Of autopsy

131 b

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? (Specify type of place)

While at work? (e) Means of injury 2

23. Signature R. L. Hinden (M. D. or other) D.O.

Address Callao, Mo Date signed 9/20/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-41-1866
Date Filed ------OCT-17-1941-----

**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 D. S. Edwards

Licensed Embalmer No. 1961

P. O. Address Bevier Mo.

**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.**