

FILED APR 13 1942

Registration District No. _____

Primary Registration District No. 2002Registrar's No. 67

1. PLACE OF DEATH:

(a) County Jasper
 (b) City or town Joplin
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Freeborn Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution FEB 2, 1942
 (Specify whether
 In this community 38 YEARS
 years, months or days)

3. (a) PRINT FULL NAME

ROBERT L. Wingo
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MM 5. Color or race W 6. (a) Single, widowed, married, divorced, div
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased SEPT 11 1877
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 5 22 hr. min.

9. Birthplace Nelsonville Ohio
 (City, town, or county) (State or foreign country)

10. Usual occupation PHOTOGRAPHER

11. Industry or business _____

MOTHER FATHER { 12. Name NO RECORD

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 Paul Wingo

(b) Address 824 COMMON

17. (a) BURIAL (b) Date thereof 3 9 42
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HOMY HOPE CEM

18. (a) Signature of funeral director Thornhill-Dillon

(b) Address 4th & Wall

19. (a) 3-7-42 (b) Edw. S. Schaefer
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
 (c) City or town Joplin 040
 (If outside city or town limits, write "RURAL")
 (d) Street No. 824 COMMON
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 5
 year 1942 hour 1 minute 35 P M.

21. I hereby certify that I attended the deceased from
2-3 1942 to 3-5 1942

that I last saw him alive on 3-5 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration ?

Due to Intra-Cranial Thrombosis ?

Due to Hypostatic Pneumonia 3 wks

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy _____

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 _____

23. Signature Edw. S. Schaefer (M. D. or D. O.)

Address Joplin, Mo. Date signed 3-7-42

42-3.233

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..... ~~4008~~ Don Petrus

Licensed Embalmer No. 4008

P. O. Address. Goplin

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11082

Registration District No. 414

Primary Registration District No. 2002

Registrar's No.

1. PLACE OF DEATH:

(a) County Yagoper

(b) City or town Yagoper
(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)

3. (a) PRINT FULL NAME Robert L Wingo

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

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

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

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

8. AGE: Years 64 Months 5 Days 10
(If less than one day 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.....
(Burial, cremation, or removal) (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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. Day 21 Year 1942 Hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Postnatal Pneumonia (Bronchial)

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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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 R. M. James (M. D. or other)
Address Jefferson, Mo. Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-11082

1942