

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 9 1943 7
Registration District No.

Primary Registration District No. 4218

Registrar's No. 159

1. PLACE OF DEATH:

(a) County Henry
 (b) City or town Windsor
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
104 South Commercial
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20 years (Specify whether
 In this community 20 years
 years, months or days)

3. (a) PRINT FULL NAME Mrs. Sarah E. Scrimager

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

4. Sex Fe 5. Color or race white 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Jasper L. Scrimager 6. (c) Age of husband or wife if alive 46 years
 7. Birth date of deceased unknown-unknown 1891
 (Month) (Day) (Year)

8. AGE: Years 52 Months unknown Days unknown If less than one day
 hr. min.

9. Birthplace Henry County Missouri
(City, town, or county) (State or foreign country)10. Usual occupation at home

11. Industry or business

MOTHER FATHER { 12. Name James Waddill
 { 13. Birthplace unknown Missouri
 (City, town, or county) (State or foreign country)
 { 14. Maiden name unknown
 { 15. Birthplace unknown unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Jasper L. Scrimager
(b) Address Windsor, Missouri17. (a) Burial (b) Date thereof 7-19-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calhoun, Missouri18. (a) Signature of funeral director Huston-Turner
(b) Address Windsor, Missouri19. (a) July 31 1943 (b) Georgia Kitchen
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
 (c) City or town Windsor
 (If outside city or town limits, write "RURAL")
 (d) Street No. 104 South Commercial
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17
year 1943 hour 4:00 a minute M.21. I hereby certify that I attended the deceased from 25 1943 to July 17 1943
that I last saw him alive on July 17 1943
and that death occurred on the date and hour stated above.Immediate cause of death Acute myocardial infarction
Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 W. Windsor (M. D. or other) C
Address Date signed 7-17
43

RECEIVED

District Health Officer No. 7,

District File Number 7-43-782

Date Filed 8-6-43

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 Ernest M. Zinsler

Licensed Embalmer No. 339

P. O. Address Union Mo

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

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

FILED AUG 10 1943

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 107Primary Registration District No. 4218Registrar's No. 159

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Windsor
(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 Sarah E. Schrieger(b) If veteran,
name war _____(c) Social Security
No. _____4. Sex F Color or
race W6. (a) Single, widowed, married,
divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if
alive _____ year7. Birth date of deceased _____
(Month) (Day) (Year)8. AGE: Years 52 Months _____ Days _____
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 _____
(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 July Day 17
year 1943 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 acute nephritis Duration _____Due to Probably congestiveDue to chronic nephritisOther conditions _____
(Include pregnancy within 3 months of death)Major findings: 131b
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 [Signature] (M. D. or other)Address [Address] Date signed 8-12

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

SUPPLEMENTARY

MOTHER FATHER

11w

43

S-25059