

S. No. 2  
M-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23415

State File No. ....

FILED JUN 8 1945  
Registration District No. 131817

Primary Registration District No. 3006

Registrar's No. 165

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

1. PLACE OF DEATH  
(a) County Boone  
(b) City or town Calumna  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Ellie Fischer State Cancer Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days (Specify whether)

3. (a) PRINT FULL NAME Cheesman, Winona Burton  
3. (b) If veteran, name war ..... 3. (c) Social Security No. ....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Jan 2 1871  
(Month) (Day) (Year)

8. AGE: Years 74 Months 6 Days 7 If less than one day hr. min.

9. Birthplace Wapella Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name William Hoak  
13. Birthplace Virginia  
(City, town, or county) (State or foreign country)

14. Maiden name Nettie Sheaffer

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

16. (a) Informant Jessie Cheesman

(b) Address Bk 105, Marline, Mo.

17. (a) Removal (b) Date thereof 6-9-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marline, Mo.

18. (c); Signature of funeral director Harriet Laughlin

(b) Address Marline, Mo.

19. (a) 6-10-46 (b) E. O. Barber  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Linn 58  
(c) City or town Marline 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country .....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day ninth  
year 1945 hour 12 minute 45 p.M.

21. I hereby certify that I attended the deceased from 6-5-45, 19... to 6-9-, 19...  
that I last saw h. u alive on 6/9/45, 19...  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Kidney Duration 1 yr  
Due to .....

Due to .....

Other conditions Acute Gastritis W. F. W. S.  
(Include pregnancy within 3 months of death) PHYSICIAN  
Major findings: See above  
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? no (Specify type of place) (e) Means of injury .....

23. Signature J. McPherson (M. D. or other) M.D.  
Address Calumna Hospital Calumna, Mo. Date signed .....

1250

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 7-16-45

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..... *Dale Bundy*

Licensed Embalmer No. 4088

P. O. Address *Marshall 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.**