

FILED AUG 22 1946

State File No. ....

Registration District No. ....

Primary Registration District No. 4012

Registrar's No. ....

1. PLACE OF DEATH:  
(a) County Atchison  
(b) City or town Rock Port mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: County home 5  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: \_\_\_\_\_ (Specify whether)  
In this community most of life years, months or days

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 \_\_\_\_\_

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 1 year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from July 1 - 1946 to July 1 - 1946 that I last saw her alive on July 29 - 1946 and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced 9  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

Immediate cause of death vascularis of liver Duration 1 yr

8. AGE: Years 80 Months B Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace North Carolina (City, town, or county) (State or foreign country)

10. Usual occupation house wife

11. Industry or business \_\_\_\_\_

12. Name Jessie Maddy

13. Birthplace unknown (City, town, or county) (State or foreign country)

14. Maiden name unknown

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

16. (a) Informant Cornet Perry

(b) Address Rock Port mo

17. (a) burial (b) Date thereof Aug 3 1946 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Waldron Grove cemetery

18. (a) Signature of funeral director E E Burton

(b) Address Rock Port mo

19. (a) Beth Coates (b) Beth Coates (Data received local registrar) (Registered signature)

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? \_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. J. Davis (M. D. or other) \_\_\_\_\_  
Address Taskio Mo Date signed 8-3-46

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

25077

8-3-464

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.....

*C. E. Buttram*....., Registered Apprentice No.....  
working under my personal supervision.

Signed *C. E. Buttram*

Licensed Embalmer No. *1764*

P. O. Address *Rock Port 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.**

Registration District No. 4

Primary Registration District No. 4012

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Atchison

(b) City or town Rockport  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison

(c) City or town County Home Rural.  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Nancy C. Winnie

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

4. Sex F

5. Color or race white

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

6. (b) Name of husband or wife Walter Winnie

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

7. Birth date of deceased: Jan (Month) 2 (Day) 1898 (Year)

8. AGE: Years 80 Months 6 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (Registrar's signature)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

20171