

FILED MAY 31 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16276

BIRTH NO. _____ REG. DIST. NO. 96 PRIMARY REG. DIST. NO. 4158 Registrar's No. 24

| | | | |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Dallas</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dallas</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Buffalo, Mo.</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Grant</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | d. STREET ADDRESS (If rural, give location) <u>Louisburg, Mo.</u> | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Annie</u> b. (Middle) <u>Laurie</u> c. (Last) <u>Wing</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>5-13-1950</u> |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M.</u> | 8. DATE OF BIRTH <u>Aug. 29-1873</u> |
| 9. AGE (In years last birthday) <u>76</u> | | IF UNDER 1 YEAR Months <u>8</u> Days <u>14</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/> | 11. BIRTHPLACE (State or foreign country) <u>Dallas Co. Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13a. FATHER'S NAME <u>John M. Connell</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>W. Brown</u> | | 14. NAME OF HUSBAND OR WIFE <u>J. F. Wing</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/> | |
| 17. INFORMANT'S SIGNATURE OR NAME <u>J. F. Wing</u> ADDRESS <u>Louisburg, Mo.</u> | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u> | |
| ANTECEDENT CAUSES | | DUE TO (b) <u>Diabetic gangrene</u> <u>2 wks</u> | |
| Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | DUE TO (c) <u>Diabetes meli.</u> <u>1 yr?</u> | |
| II. OTHER SIGNIFICANT CONDITIONS | | Conditions contributing to the death but not related to the disease or condition causing death. <u>210X</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>10 May, 1950</u> , to <u>13 May, 1950</u> , that I last saw the deceased alive on <u>13 May, 1950</u> , and that death occurred at <u>8:45 p.m.</u> , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE (Degree or title) <u>A. Ruffen MD</u> | | 23b. ADDRESS <u>Buffalo, Mo.</u> | |
| 23c. DATE SIGNED <u>16 May 50</u> | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>5-15-50</u> | |
| 24c. NAME OF CEMETERY OR CREMATORY <u>Union Home</u> | | 24d. LOCATION (City, town, or county) (State) <u>Dallas Co. Mo.</u> | |
| DATE REC'D BY LOCAL REG. <u>5/27/50</u> | | REGISTRAR'S SIGNATURE <u>Dr. J. B. James</u> | |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>Montgomery-Vaughan</u> | | ADDRESS <u>Buffalo Mo</u> | |

(Licensed Embalmer's Statement on Reverse Side)

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

2300

RECEIVED 5129.50
District Health Officer No. _____
District File Number 450.55
Date Filed 512915

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 _____

working under my personal supervision.

Student Embalmer No.

Signed
Student Embalmer

Signed *Blyde Montgomery*
Licensed Embalmer No. 3592

P. O. Address *Buffalo, 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.