

UNITED STATES DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **29129**

FILED OCT 14 1948

Registration District No. **35**

Primary Registration District No. **3011**

Registrar's No. **1**

1. PLACE OF DEATH:

(a) County **Carroll**  
(b) City or town **Carrollton**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Southside Hosp.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4 1/2 months**  
In this community **Life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **FRANCES Emily WINFREY**

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

4. Sex **Fe** 1. Color or race **W**  
5. Color or race **W**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Benjamin Winfrey**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **July 13 1902**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**46 1 26** hr. min.

9. Birthplace **Carroll Co Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

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

12. Name **John Chandler**

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

14. Maiden name **Emma Minnie**

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

16. (a) Informant **Joe Chandler**

(b) Address **Carrollton Mo**

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof **9-11-48**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Oak Hill Cem**

18. (a) Signature of funeral director **Stanley J. Baker**

(b) Address **Carrollton Mo**

19. (a) **9/10/48** (b) **Tom Parker**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Carroll**  
(c) City or town **Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **9**  
year **1948** hour **3** minute **30** M.

21. I hereby certify that I attended the deceased from **Aug 19 1948** to **Sept 9 1948**, that I last saw her alive on **Sept 9 1948** and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of Cervix**  
Duration \_\_\_\_\_

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations **H&O**

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 **2**

23. Signature **Dr. Fred C. Baker** (or other) \_\_\_\_\_

Address **Carrollton Mo** Date signed **9/9/48**

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

RECEIVED  
District Health Officer No. 8,  
District File Number \_\_\_\_\_  
Date Filed \_\_\_\_\_

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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 Bert W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton

**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.**