

REC'D OCT 12 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

31902
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 35
(b) Township St Joseph Primary Registration District No. 35 Registered No. 946
(c) City St Joseph (d) Street No. No. Mecho Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. 14 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 500 Virginia Lou Winn (WINN) St. Plattsburg Mo
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Single</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov 29 - 1897</u>		
7. AGE	YEARS <u>41</u>	MONTHS <u>9</u>
	DAYS <u>14</u>	If LESS than 1 day, hr. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housekeeper</u>	11. Total time (years) spent in this occupation <u>8</u>
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Housekeeping</u>	
	10. Date deceased last worked at this occupation (month and year)	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Plattsburg Mo</u>		
FATHER	13. NAME <u>Arnold Winn</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>	
MOTHER	15. MAIDEN NAME <u>Rosie Harstell</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>	
17. INFORMANT (ADDRESS) <u>Mrs. Grace Scelie Plattsburg Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Plattsburg Mo</u> DATE <u>Sept 14 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>W. L. Winn Plattsburg Mo</u>		
20. FILED <u>Sept 13 1939</u> <u>A. J. Nestelbusch</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 13 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 31 - 1939 to Sept 13 1939
I last saw him alive on 9-12-1939. Death is said to have occurred on the date stated above, at 3:20 a.m.
The principal cause of death and related causes of importance were as follows:
Estimated cause is "embolism" location unknown. Sudden.

Other contributory causes of importance:
Intestinal obstruction - Patent foramen ovale

Name of operation Removal of bowell Date of 8-31-39
What test confirmed diagnosis? none Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify Paul Forgores, M. D.
(Address) St. Joseph, Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1226

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
MEMPHIS, TENNESSEE

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 860

James L. Martin, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

James L. Martin
Licensed Embalmer No. 860

P. O. Address Plattburg, 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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

31902
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
(b) Township St. Joseph Primary Registration District No. 1001 Registered No. 946
(c) City St. Joseph (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Virgie Lou Winn

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
41 9 14

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as bank, mill, etc.

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 9-13 1939 J. J. West Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 13 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the _____ stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Estimated Cause is Date of onset _____

Embolism Sudden

Intestinal obstruction

Patent Foramen ovalis

Intestinal obstruction due to

Intestinal obstruction due to

Name of operation _____ Date of _____
What was the confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
What did injury occur? _____
(Specify city, town, county, and State)

Specify whether injury occurred in _____, in home, or in public place.

Manner of injury _____
Cause of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) Paul J. Jorgensen, M. D.
(Address) St. Joseph, Mo.

SUPPLEMENTARY

to be filed with the original certificate

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN, or other state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-31902