

31205

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 4010 OCT 23 1940Primary Registration District No. 4010Registrar's No. 40

1. PLACE OF DEATH:

(a) County Andrew
(b) City or town Savannah
(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 _____ years, months or days 75 yrs3. (a) PRINT FULL NAME William Winter

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m6. (b) Name of husband or wife Hellie Winter 6. (c) Age of husband or wife if alive 70 years7. Birth date of deceased 3-15-1865
(Month) (Day) (Year)8. AGE: Years 75 Months 6 Days 17 If less than one day _____ hr. _____ min.9. Birthplace Andrew Co Mo
(City, town, or county) (State or foreign country)10. Usual occupation Common Laborer

11. Industry or business _____

12. Name William Winter13. Birthplace Andrew Co Mo
(City, town, or county) (State or foreign country)14. Maiden name un known15. Birthplace un known
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Mrs. Hellie Winter(b) Address Savannah Mo17. (a) Burial (b) Date thereof 10-9-1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Bennett Lane18. (a) Signature of funeral director E. C. Breit(b) Address Savannah Mo19. (a) Oct. 4 - 40 (b) Mrs. Jennie Raab
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew(c) City or town Savannah Mo
(If outside city or town limits, write "RURAL")(d) Street No. 0
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7
year 1940 hour about 5:45 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Chronic Interstitial Nephritis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____Of autopsy Kidney Degeneration

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? _____

934
While at work _____ (Specify type of place) _____23. Signature Dr. Clifford L. Herdley M.D. or other DOAddress Savannah Mo Date signed 10/7/40

(Licensed Embalmer's Statement on Reverse Side)

Carroll Andrew County

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

Rev. 5-17-39
1-X19511

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.

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..... *E. C. Breit*

Licensed Embalmer No. *2650*

P. O. Address. *Savannah Ga*

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.