

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

1932
Do not use this space.

FILED JAN 31 1944

1. PLACE OF DEATH
 (a) County Andrew Registration District No. 7
 (b) Township W. Salina Primary Registration District No. 5 Registered No. 4
 (c) City Clark R R 13 (d) Street No. 1 St. 0
 (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 James Joseph Winn
 (a) Residence, No. [] St. [] (If nonresident, give city or town and State) 1
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED - HUSBAND OF (or) WIFE OF Coxe Belle Pollard
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3/14/1867
 7. AGE YEARS 76 MONTHS 9 DAYS 8 If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, 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) Boone Co. Mo.
 FATHER 13. NAME James Joseph Winn
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know
 MOTHER 15. MAIDEN NAME Wesie Ellen Brink
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clark Co. Ky
 17. INFORMANT (ADDRESS) Lester Winn
Clark R R
 18. BURIAL, CREMATION, OR REMOVAL PLACE [] DATE 12/26/43
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Fred A. Thompson
Madison, Mo.
 20. FILED 12/23/43 1477 Municipal Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 22 1943
 22. I HEREBY CERTIFY, That I attended deceased from July 6 1943 to Dec 22 1943
 I last saw him alive on Dec 22 1943 Death is said to have occurred on the date stated above, at 8 P.M.
 The principal cause of death and related causes of importance were as follows:
Lobar pneumonia of lung
105
 Other contributory causes of importance:
Cardio-Renal alone
 Name of operation..... Date of.....
 What test 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.....
 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.....
 (Signed) Dr. J. H. Tomlinson, M.D.
 (Address) Sturgeon, Mo.

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.....

Mrs. Justa Thompson

Licensed Embalmer No. *2282*

P. O. Address *Madison*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. FILED FEB

Registration District No. 9 Primary Registration District No. 5025 Registrar's No. 5

1. PLACE OF DEATH:

(a) County Audrain
(b) City or town Sailing Jump, Clark Co.
(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 Mo (b) County Audrain
(c) City or town Clark IN
(If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

James J. Winn

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 m

6. (b) Name of husband or wife Cora Belle 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Mar 14 (Month) (Day) (Year)

8. AGE: Years 26 Months 9 Days _____ (Less than one day) min.

9. Birthplace Boase Mo (City, town or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name James J. Winn

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

14. Maiden name Dora E. Birch

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

16. (a) Informant Arthur Winn

(b) Address Clark Mo Rk

17. (a) Prosser (b) Date thereof 12-26-43 (Month) (Day) (Year)

(c) Place: burial or cremation Fred A. Thompson

18. (a) Signature of funeral director Madison Mo

(b) Address _____

19. (a) 1-2-1944 (b) (Mrs. Arch Clayton) (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Year 1943 Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis of st. larynx

Due to _____
Due to _____

Other conditions CardioRenal Adema (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 W. J. H. Jones (Print name or other) _____

Address Sturgis Mo

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Supplemental

1932