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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

23944

State File No.

FILED AUG 2 1944

Registration District No. 749

Primary Registration District No. 1002

Registrar's No. 3019

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, MO (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Childrens Mercy Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 Days (Specify whether years, months or days) 0

In this community 20 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon 61

(c) City or town Rural Macon. 0 (If outside city or town limits, write "RURAL")

(d) Street No. Rte # I (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country ✓ 1

3. (a) PRINT FULL NAME Betty Maxine Winkler

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex 7 1

5. Color or race W

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March (Month) 5 (Day) 1930 (Year)

8. AGE: Years 14 Months 4 Days 14 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation school student

11. Industry or business

FATHER
12. Name Geo. D. Winkler
13. Birthplace (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Lorene Saunders
15. Birthplace (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Geo. D. Winkler

(b) Address Macon Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-20-44 (Month) (Day) (Year)

(c) Place: burial or cremation Macon Mo.

18. (a) Signature of funeral director Steve McClure

(b) Address 3235 Gillham Plaza KC MO.

19. (a) 7-21-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7-19 day year 1944 hour 9 minute 40 P. M.

21. I hereby certify that I attended the deceased from 6-29-44, 19, to 7-19, 1944; that I last saw her alive on 7-19, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Post Mortem
1 Hodgkins disease

Due to i splenomegaly, hepatomegaly &

Due to generalized lymphadenopathy
2 Bronchopneumonia

Other conditions (Include pregnancy within 3 months of death) 3 Ascites

Major findings of operations 4 Hydrothorax 5 Pleurisy.

Of autopsy 6 Hydropericardium 7 Passive congestion

Duration

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) 7 Chr. viscera

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature John H Garkin M.D. (M. D. or other)

Address Mercy Date signed 7-20-44

(Licensed Embalmer's Statement on Reverse Side)

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. M. Pleasler

Licensed Embalmer No. 1848

P. O. Address K. C. 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.