

FILED APR 12 1945

Registration District No. 176

Primary Registration District No. 3026

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Independence Sanitarium
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community about 25 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Independence
(If outside city or town limits, write "RURAL")
 (d) Street No. 219 North Pleasant
(If rural, give location)
 (e) Citizen of foreign country? 1 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Fanny Lee Winger

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife William H Winger 6. (c) Age of husband or wife if alive 41 years
 7. Birth date of deceased: January 30 1896
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>49</u>	<u>1</u>	<u>5</u>	hr. _____ min. _____

9. Birthplace: Osessa Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: Teacher

11. Industry or business: School Principal

12. Name: Rowan B Snyder

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

14. Maiden name: Fannie Lee Gibbs

15. Birthplace: Osessa Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant: H. H. Winger

(b) Address: 219 N. Pleasant

17. (a) 13-4-43 (b) Date thereof: March 8-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Osessa - Missouri

18. (a) Signature of funeral director: W. Mitchell, Funeral Home

(b) Address: 310 N. Main St Independence Mo

19. (a) 3-8-45 (b) J. J. Jernigan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 5
 year 1945 hour 8 minute 25 A. M.

21. I hereby certify that I attended the deceased from Feb 11/45 1945, to March 5 1945
 that I last saw him alive on March 5 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Bronchitis
Bi lateral Bronchid

Due to: Asthma - Acute

Due to: Probably bacterial

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: Of operations: None

Of autopsy: None

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: Georget Taylor (M. D. or other) _____
 Address: Independence Mo Date signed: 7/6/45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

8
4
4

MOTHER FATHER

1763

APR 3 1948

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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed Henry J. Mitchell
Licensed Embalmer No. 3925
P. O. Address Indep. 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.