

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13769**

FILED MAY 10 1945
1970

Registration District No. _____

Primary Registration District No. **5628**

Registrar's No. _____

53
0
0
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Laclede**
(b) City or town **Rural, Missouri**
(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 **20 years**
years, months or days

3. (a) PRINT FULL NAME **CHRISTINA WINKLE**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Wm Winkler** 6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **March 16 1869**
(Month) (Day) (Year)

8. AGE: Years **76** Months **0** Days **2** If less than one day hr. min.

9. Birthplace **Pulaski Co MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Wm Henry Harrison**

13. Birthplace **Carlton Co MO**
(City, town, or county) (State or foreign country)

14. Maiden name **Marry Harrison**

15. Birthplace **Carlton Co. MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Wm Winkler**

(b) Address **Winnepeg**

17. (a) **Rural** (b) Date of **Nov 20 45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Carvel Cemetery**

18. (a) Signature of funeral director **none**

(b) Address _____

19. (a) **May 1 45** (b) **Grace Poppe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Laclede**
(c) City or town **Rural** **53**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) _____
(e) Citizen of foreign country? _____ (Yes or No) _____
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **18** th
year **1945** hour **2** minutes **30 P.** M.

21. I hereby certify that I attended the deceased from **Mar 15**, 19**45** to **Mar 18**, 19**45**

that I last saw her alive on **Mar 18**, 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Diabetes Mellitus**

Duration _____

Due to _____

Due to _____

Other conditions _____
(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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature **Dr. Wm C. Ritchey** (Name or other) **Do**

Address **Plato, Mo** Date signed **3/28/45**

PHYSICIAN

Underline the cause to which death should be charged statistically.

Received

LaCade County Health Unit

File No. 4-45-37

Date Filed 5/8/45

Births
5630
Hismang

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.....

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

Signed *Dorsey M. Howe*

Licensed Embalmer No. *4222*

P. O. Address *Lebanon 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.