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**FILED SEP 10 1946** STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 294

Primary Registration District No. 3056

Registrar's No. 168

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Boberly Mo.  
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 2 days  
(Specify whether years, months or days)

In this community 72yrs IImo 20da.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph **88**

(c) City or town Higbee Mo Rural **0**  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) **0**

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) **1**

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John M. Winn

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day II  
year 1946 hour 9 minute 15 p.m.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Laura Winn 6. (c) Age of husband or wife if alive years

7. Birth date of deceased: Aug. 21 1873  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 9  
1946 to Aug 11, 1946;  
that I last saw him alive on Aug 11, 1946;  
and that death occurred on the date and hour stated above.

Immediate cause of death Mesentery Thrombosis **Duration**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 72 Months II Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Howard Mo. (City, town, or county) (State or foreign country) **MO**

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy NO **PHYSICIAN**

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name James Winn

13. Birthplace Boone Co. (City, town, or county) (State or foreign country) **0**

14. Maiden name Mary Naylor

15. Birthplace Boone Co. (City, town, or county) (State or foreign country) **0**

16. (a) Informant Mrs Laura Winn

(b) Address Higbee Mo.

17. (a) Burial (b) Date thereof Aug. 14 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Perche Church

18. (a) Signature of funeral director Joe W Burton

(b) Address Higbee Mo

19. (a) 8-14-46 (b) Seal William Lane  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(e) 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 J. H. Winn (M. D. Winn) **0**

Address Higbee, MO. Date signed 8/15/46

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

269

RECEIVED  
District Health Officer No. 10  
District File Number 9-46-1662  
Date Filed SEP 7 1946

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 Ed Friedman

Licensed Embalmer No. 3978

P. O. Address Glasgow M

**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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept  
Registrar's No. 168

Registration District No. 294 Primary Registration District No. 3056

1. PLACE OF DEATH:

(a) County Randolph  
(b) City or town Moberly  
(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)

3. (a) PRINT FULL NAME John M. Wren

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 married

6. (b) Name of husband or wife Laura 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Aug 2, 1921  
(Month) (Day) (Year)

8. AGE: Years 72 Months 20 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 Aug year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; what I first saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

28094