

No. 2  
1739  
X37823

**FILED SEP 25 1946** STANDARD CERTIFICATE OF DEATH

State File No. **31234**

Registration District No. **316**

Primary Registration District No. **3059**

Registrar's No. **280**

**1. PLACE OF DEATH:**

(a) County St. Francois  
(b) City or town Bonne Terre  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Bonne Terre Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 weeks  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Iron  
(c) City or town Middlebrook  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Robert Moses Winder

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, married

6. (b) Name of husband or wife Ida May Winder 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased January 22 1879  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>7</u>	<u>14</u>	hr. _____ min.

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

10. Usual occupation Retired- section foreman

11. Industry or business Rail Road

12. Name Wm. C. Winder

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

14. Maiden name unknown

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

16. (a) Informant Mrs. Ida May Winder

(b) Address Middlebrook Mo.

17. (a) burial (b) Date thereof 9-8-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Middlebrook Mo.

18. (a) Signature of funeral director Norman White & Sons

(b) Address Ironton Mo.

19. (a) 9-11-46 (b) Ether Rudloff  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept day 6  
year 1946 hour 4 minute 55 P.M.

21. I hereby certify that I attended the deceased from Aug 15 1946 to Sept 6 1946  
that I last saw him alive on 9-6  
and that death occurred on the date and hour stated above.

Immediate cause of death arterio-sclerotic insufficiency  
Duration with

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

Other conditions hypertension  
(Include pregnancy within 3 months of death)  
Major findings fr. femur thru trochanter  
Of operations received in jail

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be ascribed statistically.  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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. O. Gaelle (M. D. or other) \_\_\_\_\_  
Address Deolage Mo Date signed 9-9-46

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

MOTHER FATHER

MAY 25 1948

RECEIVED

District Health Officer No. 4  
File Number 946-2652  
Date 9-24-46

OCT 20 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.....

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

Signed ancel white

Licensed Embalmer No. 2012

P. O. Address San Antonio

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.

Registration District No. *316*

Primary Registration District No. *3059*

Registrar's No. *280*

1. PLACE OF DEATH:

(a) County *St Francois*  
(b) City or town *Booneville*  
(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)

3. (a) PRINT FULL NAME *Robert M. Winder*

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

7. Birth date of deceased *Jan 22 1902*  
(Month) (Day) (Year)

8. AGE: Years *67* Months *7* Days *22* (if less than one day) hr. min.

9. Birthplace (City, town, or county) (State or foreign country) *Ill*

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER } 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) (Date received local registrar) (b) (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 *1968* hour *10* minute *15* M.

21. I hereby certify that I attended the deceased from *10/10/68* to *10/10/68*, 19*68*; that I last saw him *alive* on *10/10/68*, 19*68*; 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) *accident*

(b) Date of occurrence *8-15-68*

(c) Where did injury occur? *Patrol Room No. 1*  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
*in garden of house*

While at work? *Yes* (Specify the place) (Specify the means of injury)

23. Signature *Dea by 2 No* (M. D. or other) *10-10-68*

Address..... Date signed.....

SUPPLEMENTARY

30065 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

31234