

FILED JAN 30, 1947

Registration District No. _____

Primary Registration District No. 5035

Registrar's No. 11

1. PLACE OF DEATH:

(a) County: Audrain
(b) City or town: Rural - Saline
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R.F.D. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community: all of life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Audrain
(c) City or town: Rural
(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: Hannie Wincott

3. (b) If veteran, name war: _____ (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: Merrett Wincott 6. (c) Age of husband or wife if alive: 66 years

7. Birth date of deceased: Dec. 3-1883
(Month) (Day) (Year)

8. AGE: Years: 63 Months: 1 Days: 19 If less than one day: _____ hr. _____ min.

9. Birthplace: Audrain Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation: Hosp.

11. Industry or business: _____

12. Name: James Christopher Parrish

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

14. Maiden name: Grace Jackson

15. Birthplace: _____ Mo. (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Bernice Parrish (b) Address: _____ Mo.

17. (a) Burial, cremation, or removal: Burial (b) Date thereof: Jan 24-1947 (Month) (Day) (Year)

(c) Place: burial or cremation: Macedonia

18. (c) Signature of funeral director: Barnes & Brotha (b) Address: _____ Mo.
19. (a) 1/24/47 (b) Blanche Neely (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1/22/47 day _____ year _____ hour 7 minute 02 P.M.

21. I hereby certify that I attended the deceased from 1/8/47 to 1/22/47 that I last saw her alive on 1/20/47 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Embolism

Due to: Essential Hypertension

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

Major findings: Of operations: _____ Of autopsy: 44A

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) (c) Means of injury: 2

23. Signature: J.F. Carroll M.D. (M. D. or other) _____ Address: Surgeon Mo. Date signed: 1/23/47

Duration: 1 hr
PHYSICIAN: _____
Underline the cause to which death should be charged statistically.

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

430

RECEIVED
District Health Officer No. 10
District File Number 1-47-192
Date Filed JAN 28 1947

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..... *A. E. Boothe*
Licensed Embalmer No. *4087*
P. O. Address..... *Sturgeon 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.