

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26581

FILED AUG 21 1949

BIRTH NO. _____ REG. DIST. NO. 113 PRIMARY REG. DIST. NO. 5431 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY <i>Franklin</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo</i> b. COUNTY <i>Franklin</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Rural - Prairie</i>	c. LENGTH OF STAY (in this place) <i>years</i>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Rural - Prairie - Mo</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Robertsville R #1.</i>		d. STREET ADDRESS (If rural, give location) <i>Robertsville R #1.</i>	

3. NAME OF DECEASED (Type or Print) a. (First) <i>George</i> b. (Middle) <i>Winters</i> c. (Last) <i>Winters</i>	4. DATE OF DEATH (Month) (Day) (Year) <i>8-9-49</i>
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5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>11-4-1878</i>	9. AGE (In years last birthday) <i>70</i> <input type="checkbox"/> MONTHS <i>9</i> <input type="checkbox"/> YEARS <i>4</i> <input type="checkbox"/> HOURS <i>0</i> <input type="checkbox"/> MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>General Farming</i>	11. BIRTHPLACE (State or foreign country) <i>Missouri</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Fred Winters</i>	13b. MOTHER'S MAIDEN NAME <i>Doris Wain</i>	14. NAME OF HUSBAND OR WIFE <i>Zulu</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT'S SIGNATURE OR NAME <i>Zulu Winters</i>	ADDRESS <i>Robertsville</i>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <i>11 mo.</i>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Pseudobulbar Paralysis</i>		
	ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) <i>Intra cranial hemorrhage</i>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <i>L</i>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>352X</i>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from *Oct. 1948*, to *8-9-49*, that I last saw the deceased alive on *8-9-49*, and that death occurred at *12:35 m.*, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>W. E. Kitchell M.D.</i>	23b. ADDRESS <i>St. Clair</i>	23c. DATE SIGNED <i>8-10-49</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>8-11-49</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Jefferson Burial</i>	24d. LOCATION (City, town, or county) (State) <i>St. Louis Co. Mo</i>
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DATE REC'D BY LOCAL REG. <i>8-10-1949</i>	REGISTRAR'S SIGNATURE <i>E. L. Worthington</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Herwood Kitchell</i>	ADDRESS <i>St. Clair</i>
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

----- District File Number -----

District Health Officer No. 9,

AUG 16 1949

RECEIVED

JAN 27 1950

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 -----

Student Embalmer No. -----

working under my personal supervision.

Student -----
Student Embalmer

Signed

C. Jesse Gahr

Licensed Embalmer No. *4486*

P. O. Address *St. Clair, 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.