

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33155

State File No.

FILED OCT 17 1951

BIRTH NO. 26321-51 REG. DIST. NO. 111 PRIMARY REG. DIST. NO. 5426 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Mo. b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Boles Township	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Boles Township	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) J	

3. NAME OF DECEASED (Type or Print) a. (First) Charles		b. (Middle) Mickel		c. (Last) Wines		4. DATE OF DEATH (Month) (Day) (Year) Sept. 18 51	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child		8. DATE OF BIRTH 4-27-51	9. AGE (In years last birthday) 4	IF UNDER 1 YEAR Months 23 Days	IF UNDER 1 Hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) St. Louis		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Charles Francis Wines		13b. MOTHER'S MAIDEN NAME Helen Corene Cross		14. NAME OF HUSBAND OR WIFE Child	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Helen Corene Wines	
				ADDRESS Sullivan, Mo	

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 week
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BROUCHOPNEUMONIA		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 491X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 9/18, 1951, to 9/18, 1951, that I last saw the deceased alive on 9/18, 1951, and that death occurred at 8 Pm., from the causes and on the date stated above.

23a. SIGNATURE John J. de la Torre M.D.		23b. ADDRESS Sullivan, Mo		23c. DATE SIGNED 9/20/51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-18-51	24c. NAME OF CEMETERY OR CREMATORY Cave Spring Cemetery	24d. LOCATION (City, town, or county) (State) Franklin Mo.	
DATE REC'D BY LOCAL REG. Sept-20-1951	REGISTRAR'S SIGNATURE Mary B. Cross	25. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Shaller		ADDRESS Sullivan, Mo

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

0360
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File No. _____
DISTRICT HEALTH OFFICE No. 4

OCT 14 1951

RECEIVED

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. 437

working under my personal supervision.

Student Warren Clifford Kraft
Student Embalmer

Signed _____

Licensed Embalmer No. 2692

P. O. Address Fullerton 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.