

FILED APR 1 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-009758

STATE FILE NUMBER

Registration District No. 142 Primary Registration District No. 4231 Registrar's No. 15

300  
-57

3

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mountain View</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Joseph</u> <u>0117</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Old Hy. # 60</u>		Length of stay in 'lb <u>minutes</u>	
d. STREET ADDRESS <u>2003 S. 11th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Johnnie</u> Middle <u>J.</u> Last <u>Winningham</u>			4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 31, 1911</u>
9. AGE (In years) (If birthday) <u>46</u>		10. FUNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	11. BIRTHPLACE (City and state or country) <u>Mtn. View, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Wash Winningham</u>	
13b. MOTHER'S MAIDEN NAME <u>Martha E. House</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>440-30-5019</u>	17. INFORMANT Address <u>Lottie Smith, Summersville, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Skull</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Compound Fracture left Leg 046</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Was walking across highway and</u>	
20c. TIME OF INJURY Hour <u>9:15</u> Month <u>3</u> Day <u>22</u> Year <u>58</u> p.m.		<u>was struck by Pick Up Truck</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>U.S. Hwy # 60</u>	
20f. CITY, TOWN, OR LOCATION <u>Mtn. View</u>		COUNTY <u>Howell</u> STATE <u>Mo.</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>9:15 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joe R. Duncan Coroner</u>		22b. ADDRESS <u>Mtn. View, Mo.</u>	
22c. DATE SIGNED <u>3-25-58</u>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/25/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Mtn. View, Mo.</u>
24. FUNERAL DIRECTOR <u>Duncan Funeral Home Mtn View Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-29-58</u>	26. REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 .....  
Signature of Student Embalmer

Signed *Richard A. Norton*

Licensed Embalmer No. *5029*

P. O. Address *Mt. View, N.J.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.