

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-043442

STATE FILE NUMBER

FILED DEC 29 1958

Registration District No.

47

Primary Registration District No.

3008

Registrar's No.

290

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton, Mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sturgeon, Mo.</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>St. Hospital No. 1,</u>		Length of stay in lb <u>14 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>D.K.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Proctor</u> Middle Last <u>Winscott</u>			4. DATE OF DEATH Month <u>Dec.</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 checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1883</u>		9. AGE (In years) If under 1 year: Months <u>7</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> If under 1 year: Months <u>7</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dr</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>unk.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>James Hampton Winscott</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Proctor</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>D.K.</u>		17. INFORMANT <u>Hospital Records</u> Address <u>Fulton, 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>Bronchopneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH
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>Mental Deficiency</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input 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>491X</u>		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>March 20, 1944</u> to <u>Dec. 22, 1958</u> and last saw <u>her</u> alive on <u>Dec. 22, 1958</u> on the date stated above; and to the best of my knowledge, from the causes stated. Death occurred at <u>8:45 a.m.</u>					
22a. SIGNATURE <u>Erwin Leonhardt, M.D.</u> (Degree or title)			22b. ADDRESS <u>State Hospital No. 1, Fulton, Mo.</u>		22c. DATE SIGNED <u>12/22/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 23-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pisgah Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Near Sturgeon, Mo.</u>
24. GENERAL DIRECTOR <u>Paul J. Meador, Centralia, Missouri</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>Dec. 22-1958</u>		26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JAN 7 1959

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 *Bill J. Madon* .....

Licensed Embalmer No. *4876* ..... P. O. Address *4876* .....

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.