

UNITED STATES DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039161

FILED VS DEC 1 1959 47

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 3008 Registrar's No. 309

MAILED

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Callaway</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton</b>		Length of stay in 1b <b>90 Yrs.</b>	c. CITY OR TOWN <b>Fulton</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>214 W. 9th St.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>214 W. 9th St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Lorenzo</b> Middle <b>David</b> Last <b>Winscott</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>27</b> Year <b>1959</b>			
--	--	--	--	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/26/1897</b>	9. AGE (last birthday) <b>62</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	----------------------------------	---	---------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Hospital Attendant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Attendant</b>	11. BIRTHPLACE (City and state or country) <b>Callaway Co. Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
---	---	---	---

13a. FATHER'S NAME <b>William A. Winscott</b>	13b. MOTHER'S MAIDEN NAME <b>Lucinda Jane Sanders</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs. Effie Winscott</b>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes go, or unknown)   (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>491 24 0138</b>	17. INFORMANT Address <b>Mrs. Effie Winscott, Fulton, Mo.</b>
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
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)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
---	---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year	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 <b>July 1957</b> to <b>Nov 27, 1959</b> and last saw her/him alive on <b>Nov 27, 1959</b> Death occurred at <b>12:00 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE (Degree or title) <b>James E. Hill MD</b>	22b. ADDRESS <b>Fulton, Mo</b>	22c. DATE SIGNED <b>11-28-59</b>
---	-----------------------------------	-------------------------------------

23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov. 29, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Callaway Mem. Gdns.</b>	23d. LOCATION (City, town, or county) (State) <b>Callaway County, Mo.</b>
---	-----------------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <b>Morgan Funeral Home, Fulton Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Nov 28-1959</b>	26. REGISTRAR'S SIGNATURE <b>Martha Lawrence</b>
--	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Marshall G. Blackwell

Licensed Embalmer No. 4713

P. O. Address Fulton, Md.

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.