

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-043052

FILED VS DEC 8 1959

STATE FILE NUMBER

Registration District No. 337 Primary Registration District No. _____ Registrar's No. 99

1. PLACE OF DEATH a. COUNTY <u>SHELBY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SHELBY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAY</u>	Length of stay in 1b <u>2 YRS</u>	c. CITY OR TOWN <u>CLARENCE</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME</u>		d. STREET ADDRESS (If outside, give location) <u>RFD CLARENCE</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>RAYMOND</u> Middle <u>L</u> Last <u>WINKLER</u>			4. DATE OF DEATH Month <u>NOV</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1911</u>	9. AGE (last birthday) <u>48</u>	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) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING-MILLING</u>		11. BIRTHPLACE (City and state or country) <u>MO MACON COUNTY MO</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>
13a. FATHER'S NAME <u>MILTON WINKLER</u>		13b. MOTHER'S MAIDEN NAME <u>NELLIE ROBERTS</u>		14. NAME OF HUSBAND OR WIFE <u>VIRGINIA WINKLER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>VIRGINIA WINKLER CLARENCE MO</u> Address _____		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>instantly</u>
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>hypertension</u>	<u>5 years</u>	
DUE TO (c) <u>arteriosclerosis</u>	<u>5 years</u>	

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	
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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 <u>CLARENCE</u>	COUNTY _____ STATE _____
21. I attended the deceased from <u>7-13-1953</u> to <u>11-26-1959</u> and last saw <u>him</u> alive on <u>11-26-1959</u> Death occurred at <u>12 45</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>Alan R Hull</u>		22b. ADDRESS <u>D.O. Clarence, MO</u>		22c. DATE SIGNED <u>12-3-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-29-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAPLEWOOD CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>CLARENCE MO</u>		
24. FUNERAL DIRECTOR <u>BRENNING CLARENCE MO</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>Dec 4-59</u>	26. REGISTRAR'S SIGNATURE <u>Ada Garrison</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 17 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles V. Green

Licensed Embalmer No. 4625

P. O. Address Clarence

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.