

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-046656

FILED VS. JAN 16 1960 042

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1346

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 5 mon.		c. CITY OR TOWN Lexington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 306 N-18 th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last EDGAR ASBURY WINN				4. DATE OF DEATH Month Day Year December 31, 1959									
5. SEX male		6. COLOR OR RACE white		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1877		9. AGE (last birthday) 82		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) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) Dover, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME Taylor Winn				13b. MOTHER'S MAIDEN NAME JOANNE HAMPTON				14. NAME OF HUSBAND OR WIFE Sally Winn					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Sally Winn, Lexington, Mo.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lower lip										INTERVAL BETWEEN ONSET AND DEATH 4 years			
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) Chronic Brain Syndrome associated with Chr. Brain disease & Psychosis										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 s.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 Dec 26 59 to Dec 31 59 and last saw her/him alive on Dec 30 1959 Death occurred at 5 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Forrest Thomas M.D.						22b. ADDRESS State Hospital #2, St. Joseph				22c. DATE SIGNED 12/31/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 2, 1960		23c. NAME OF CEMETERY OR CREMATORY Dover Cemetery				23d. LOCATION (City, town, or county) (State) Dover, Missouri					
24. FUNERAL DIRECTOR CRUNK-WALKER - Lexington, Mo.				ADDRESS Lexington, Mo.		25. DATE RECD. BY LOCAL REG. Jan 11, 1960		26. REGISTRAR'S SIGNATURE Wm. Clark Farrell					

DOCUMENT

F. Thomas M. 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 Harold L. Walker

Licensed Embalmer No. 45-80

P. O. Address Levington,

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.