

INDIVIDUAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004654

FILED VS FEB 5 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 174 STATE FILE NUMBER

9-16-60 MISSOURI DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene St. Louis City			
b. CITY (If outside corporate limits, give TOWNSHIP only) Koch, Mo		Length of stay in 1b 23 days	c. CITY OR TOWN St. Louis Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rob'T Koch Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) -5622 Delmar- 803 E. Walnut		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Russel Middle Rayl Last Windes, Sr.			4. DATE OF DEATH Month 1 Day -16 Year -60			
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 1-5-05	9. AGE (last birthday) 58 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Credit manager		10b. KIND OF BUSINESS OR INDUSTRY Furniture Co.	11. BIRTHPLACE (City and state or country) Missouri (Washburn)		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Harry Rayl Windes		13b. MOTHER'S MAIDEN NAME Margaret Leona Wasson		14. NAME OF HUSBAND OR WIFE Bess Carter		
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. 489-26-1433	17. INFORMANT Peggy J. Windes, Springfield, Missouri -Records Koch Hospital, Koch, Mo.-			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Oedema Pulmonary Tuberculosis					INTERVAL BETWEEN ONSET AND DEATH 002+	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Partial Coarctosis					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 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.)				
20c. TIME OF INJURY Hour 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 12-24-59 to 1-16-60 and last saw <input checked="" type="checkbox"/> him alive on Death occurred at 2:15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) H. A. Harris MD			22b. ADDRESS Koch Hospital, Koch, Mo		22c. DATE SIGNED 1-16-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Remove burial 1-17-60	23b. DATE 1-19-60	23c. NAME OF CEMETERY OR CREMATORY Loe-Hill Oak Hill Cemetery	23d. LOCATION (City, town, or county) (State) Cassville Springfield, Mo.			
24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. 1-18-60	26. REGISTRAR'S SIGNATURE John B. Maffly M.D.			

STATEMENT BY LICENSED EMBALMER

MAR 10 1960

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  _____

Licensed Embalmer No. 4108

P. O. Address St. Louis

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.