

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-025848

FILED VS AUG 10 1960

Registration District No. 37 Primary Registration District No. 4049 STATE FILE NUMBER Registrar's No. 32

300  
-57

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Boone</u>                                       |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>Centralia</u>     |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <u>Centralia 01002</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                     |
| c. FULL NAME OF (If NOT in hospital, give location)<br><u>Winton Nursing Home</u> |  | Length of stay in lb<br><u>8 1/2 Mo.</u>   | d. STREET ADDRESS (If outside, give location)<br><u>217 So. Allen St.</u><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Winifred</u> Middle <u>Genelle</u> Last <u>DeJarnatt</u> |  |  | 4. DATE OF DEATH<br>Month <u>Aug</u> Day <u>3</u> Year <u>1960</u> |  |  |  |
|--|--|--|--|--|--|--|

|                         |                                  |   |   |  |   |   |
|-------------------------|----------------------------------|---|---|--|---|---|
| 5. SEX<br><u>Female</u> | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec. 13-1903</u> | 9. AGE (In years to birthday)<br><u>56</u> | IF UNDER 1 YEAR<br>Months <u>7</u> Days <u>20</u> | IF UNDER 24 HRS<br>Hours <u></u> Min. <u></u> |
|-------------------------|----------------------------------|---|---|--|---|---|

|   |   |   |   |
|---|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housekeeper</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Housekeeper</u> | 11. BIRTHPLACE (City and state or country)<br><u>Centralia, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u> |
|---|---|---|---|

|  |  |   |
|--|--|---|
| 13a. FATHER'S NAME<br><u>Hale W. DeJarnatt</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Lillian Berrey</u> | 14. NAME OF HUSBAND OR WIFE<br><u>never married</u> |
|--|--|---|

|   |  |  |         |
|---|--|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> | 16. SOCIAL SECURITY NO.<br><u>NONE</u> | 17. INFORMANT<br><u>MRS. Zella Spurling, Thompson, Mo.</u> | Address |
|---|--|--|---------|

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gastro-intestinal bleeding</u>          |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <u>Generalized metastasis</u> | <u>3 months</u>  |
|   | DUE TO (c) <u>Rectal carcinoma</u>       | <u>1 year</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Fracture left hip March 8, 1960</u> |  | 19. WAS AUTOPSY PERFORMED?<br><u>2</u> 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<br>Hour <u></u> Month, Day, Year <u></u><br>a.m. <u></u> p.m. <u></u> | 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<br><u>Centralia</u> | COUNTY<br><u>Boone</u> | STATE<br><u>Missouri</u> |
|---|--|--|--|------------------------|--------------------------|

|   |
|---|
| 21. I attended the deceased from <u>July 1, 1959</u> to <u>August 3, 1960</u> and last saw her alive on <u>August 1, 1960</u><br>Death occurred at <u>6:15</u> P. m. on the date stated above; and to the best of my knowledge, from the causes stated. |
|---|

|  |  |                                     |
|--|--|-------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><u>L. Lachance, M.D.</u> | 22b. ADDRESS<br><u>110 W. Sneed - Centralia, Mo.</u> | 22c. DATE SIGNED<br><u>Aug 5-60</u> |
|--|--|-------------------------------------|

|  |                                 |   |   |
|--|---------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 23b. DATE<br><u>Aug. 5-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Centralia Cemetery</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Centralia, Missouri</u> |
|--|---------------------------------|---|---|

|   |   |  |
|---|---|--|
| 24. FUNERAL DIRECTOR<br><u>Paul D. Ballew, Centralia, Mo.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>Aug 6-1960</u> | 26. REGISTRAR'S SIGNATURE<br><u>Maud M. E. Bride</u> |
|---|---|--|

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

AUG 17 1960

MAR 6 1963

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 *Paul J. Baller* .....

Licensed Embalmer No. *4206* .....  
P. O. Address *Centerville, Mo.* .....

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.