

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-000049

STATE FILE NUMBER

AMENDED

Registration District No. 1 Primary Registration District No. 2000 Registrar's No. 35

FILED FEB 5 1962

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Length of stay in 1b	c. CITY OR TOWN <u>Kirksville</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Laughlin Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>615 W. Pierce</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nell</u> Middle <u>Winn</u> Last			4. DATE OF DEATH Month <u>Jan.</u> Day <u>25</u> Year <u>1962</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/15/97</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Music</u>	9. AGE (last birthday) <u>64</u> IF UNDER 1 YEAR Months <u>3</u> Days <u>9</u> IF UNDER 24 HR Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>Knox Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>L. E. Kyle</u>		13b. MOTHER'S MAIDEN NAME <u>Willa Mac Nicol</u>	14. NAME OF HUSBAND OR WIFE <u>Newton E. Winn</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Ralph M. G. Smith</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Embolism</u> DUE TO (b) <u>Acute Congestive Heart Failure</u> DUE TO (c) <u>Viral pneumonia with effusion following influenza</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH Min. ? <u>153 hours</u> <u>Unknown</u>
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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>		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	
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 <u>1-24-62</u> to <u>1-25-62</u> and last saw <u>her</u> alive on <u>1-25-62</u> Death occurred at <u>3:00 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Bessie L. Sawyer DO</u>		22b. ADDRESS <u>Kirksville, Mo.</u>	22c. DATE SIGNED <u>1-27-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/29/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hills Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kirksville, Mo.</u>
24. FUNERAL DIRECTOR <u>Davis & Davis</u>		ADDRESS <u>Kirksville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-29-1962</u>
		26. REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

GRACE E. SAWYER, D.O.

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 Robert B. Paris

Licensed Embalmer No. 4219

P. O. Address Kirkville, 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.