DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 23 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH ✓

State File No. 10072

Registration District No. 37 — Primary Registration District No. 5053 — Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Barry Twp
(b) ~~City or~~ town Washburn Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether
In this community 67 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry
(c) City or town Washburn
(If outside city or town limits write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Robert Alvin Winder 537
3. (b) If veteran, name war ____ 3. (c) Social Security No. ____
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married divorced Married
6. (b) Name of husband or wife Bertie V. Winder
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased Oct (Month) 30 (Day) 1872 (Year)

8. AGE: Years 67 | Months 5 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Washburn Mo (City, town, or county) 0 (State or foreign country)
10. Usual occupation Merchant
11. Industry or business ____

MOTHER FATHER
12. Name Frank Winder
13. Birthplace Missouri (City, town, or county) 0 (State or foreign country)
14. Maiden name Cochran Rayl
15. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

16. (a) Informant Bertie V. Winder
(b) Address Washburn
17. (a) Interment (Burial, cremation, or removal) (b) Date thereof Apr 3, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Washburn Prgrve
18. (a) Signature of funeral director Koontz Funeral Home
(b) Address Cassville Mo.
19. (a) ____ (Date received local registrar) (b) C Leo Edens (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31st year 40 hour 12 minute 45 A.M.
21. I hereby certify that I attended the deceased from Mar. 24th, 1940, to Mar 31st, 1940, that I last saw him alive on Mar 31st, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic Pneumonia	5 days
Due to: Cardiac Decompensation	10 days
Due to: Rheumatic Heart disease	unk.
Other conditions (Include pregnancy within 3 months of death): Chronic Nephritis	unk.

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) No
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature Geo. D. Newman (M. D. or other)
Address Cassville, Mo Date signed 4-19-40

(Licensed Embalmer's Statement on Reverse Side)

131

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.....

Eugene Wood, Registered Apprentice No.....

working under my personal supervision.

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address Caruthersville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
1—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10072

Registration District No. 37 Primary Registration District No. 3053 Registrar's No.

1. PLACE OF DEATH:
(a) County Barry (b) City or town Washburn T. C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Robert Alvin Winder
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 67 Months 8 Days 1 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 31 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic Pneumonia	1
Due to: Bronchitis	4 hrs
Due to: Cardiac Decompensation	
Due to: Rheumatic Heart Disease	
Other conditions: (Include pregnancy within 3 months of death) Chronic Nephritis.	

Major findings:
Of operations 1321
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Geo. N. Newman (M. D. or other)
Address Carmilla Mo. Date signed

SUPPLEMENTARY

S-10072