

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space

29651

1. PLACE OF DEATH

County Buchanan
 Township Washington
 City St. Joseph

Registration District No. 86
 Primary Registration District No. 5127
 (No. Woodson Sanitarium)

File No. _____
 Registered No. 515
 St. _____ Ward _____

2. FULL NAME Alga Lincoln Wintermute

(a) Residence. No. _____ St. _____ Ward Conway, Iowa.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March, 29, 1862.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
65 7 18

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) Retired
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Taylor County,
 (STATE OR COUNTRY) Iowa.

10. NAME OF FATHER Hampton Wintermute

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) New Jersey

12. MAIDEN NAME OF MOTHER Angaline Traviola

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) New York

14. INFORMANT J. Wintermute
 (Address) Conway, Iowa.

15. FILED 10-18-27 J. J. Gaughne
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October, 17, 1927.

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on Oct 27, 1927, and that death occurred, on the date stated above, at 2:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Manicolia and gunshot wound right hip 14 years which developed Gangrene (duration) 38 yrs. mos. da.
 CONTRIBUTORY Gangrene 184 (SECONDARY) (duration) 98 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH Conway, Iowa

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

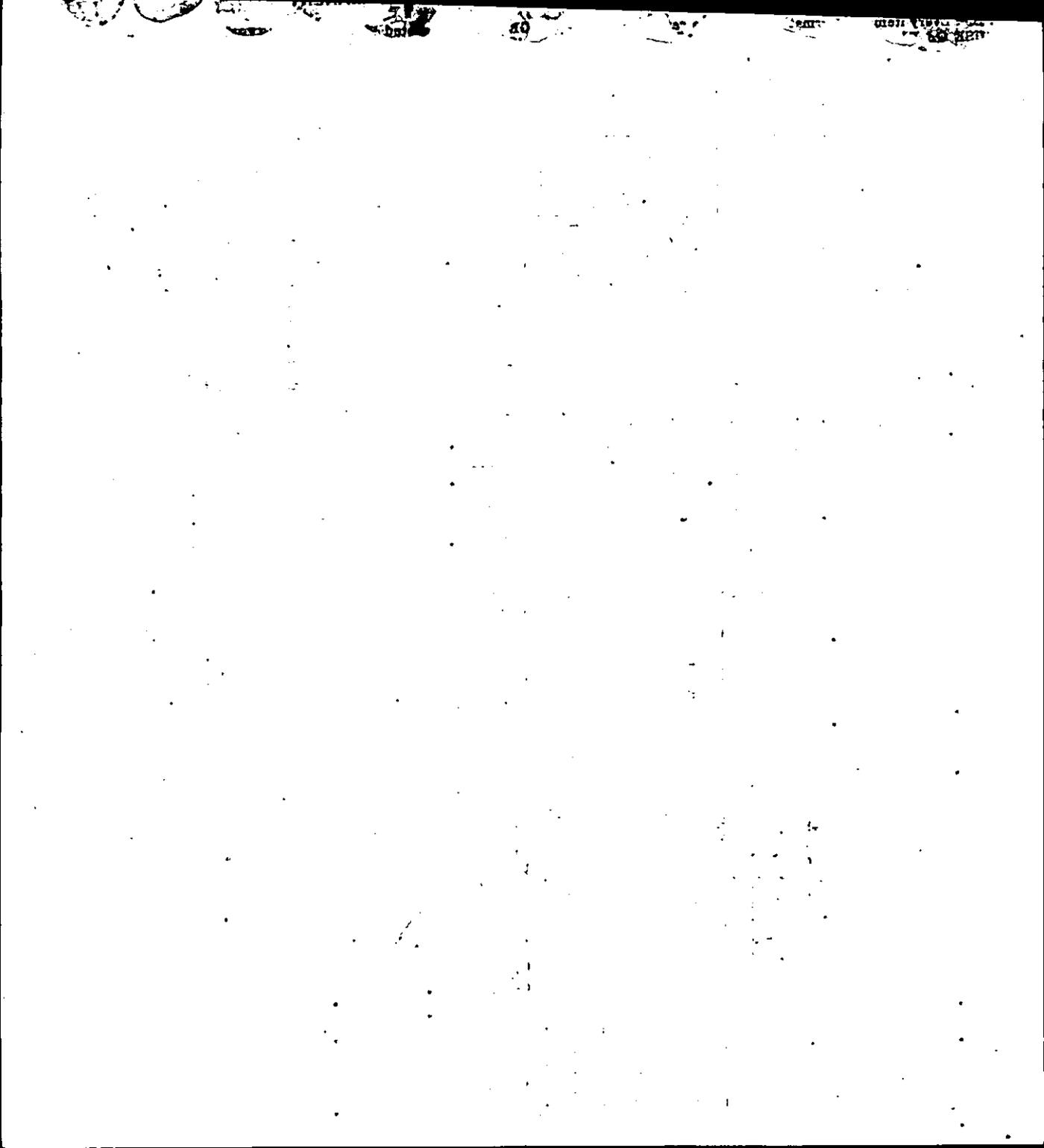
WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) R. J. Gaughne, M. D.
Oct. 18, 1927. (Address) St. Joseph Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bedford, Iowa. DATE OF BURIAL Oct. 19, 1927.

20. UNDERTAKER A. C. Schuchman ADDRESS 1802 Union Str.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important.



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Buchanan

Registration District No. 86

File No. _____

Township Washington

Primary Registration District No. 5127

Registered No. 55

City _____ (No. _____)

St. _____ Ward _____

2. FULL NAME Alga Lincoln Wintermute

(a) Residence. No. _____ St. _____ Ward _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED

19

Dec 7, 21 J. J. Rauscher
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 17 - 1927

17.

I HEREBY CERTIFY That I attended deceased from _____ to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic melancholia and gunshot wound right hip 14 years ago!
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) Gangrene was caused by wound in hip, that was inflicted year ago.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? _____ DATE _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) _____, M. D.

, 19 _____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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