

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

Do not use this space.

37009

**1. PLACE OF DEATH**

County.....*Jackson*..... Registration District No.....*399*  
 Township.....*Nash*..... Primary Registration District No.....*1002*  
 City.....*Furnessville* (No.....*Research Hospital*)..... File No.....  
 Registered No.....*10001*..... St..... Ward.....

**2. FULL NAME**

*Wm. H. Winslow*  
 (a) Residence. No.....*Shackelford, Mo.*..... 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** *Male*      **4. COLOR OR RACE** *White*      **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *Bachelor*  
 (write the word)  
**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** *Bachelor*  
**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** *Sept. 16, 1859*  
**7. AGE**      YEARS *68*      MONTHS *3*      DAYS *5*      If LESS than 1 day, hrs. or min.  
**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).....  
 (c) Name of employer.....

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

**10. NAME OF FATHER** *Henry B. Winslow*  
**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**..... *Va.*  
 (STATE OR COUNTRY)  
**12. MAIDEN NAME OF MOTHER** *Lucilla Wood*  
**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**..... *Va.*  
 (STATE OR COUNTRY)

**14. INFORMANT** *P. C. Winslow*  
 (Address) *Shackelford, Mo.*

**15. FILED** *127* *21, 1927* *M. M. Emme*  
 REGISTRAR  
*Arak*

**3 MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** *Dec. 21, 1927*  
**17. I HEREBY CERTIFY**, That I attended deceased from *5:40* *Dec 18, 1927* to *Dec 21, 1927* that I last saw him alive on *Dec 20, 1927*, and that death occurred, on the date stated above, at *6:15 a. m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Lobar Pneumonia*  
*137*  
*108* *10/10*  
 (duration) yrs. mos. ds. *5*  
**CONTRIBUTORY (SECONDARY)** *Hypertrophied*  
*Prostate* (duration) yrs. mos. ds. *3*

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH..... *Research Hospital*  
 DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *12/2/27*  
 WAS THERE AN AUTOPSY? *yes*  
 WHAT TEST CONFIRMED DIAGNOSIS? *Autopsy*  
 (Signed) *Ernest A. Mark*, M. D.  
 (Address) *1070 Holt St. Bldg.*

\*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** *Shackelford, Mo.*      **DATE OF BURIAL** *Dec. 22, 1927*

**20. UNDERTAKER** *P. V. Lindsey & Sons*      **ADDRESS** *3811 Broadway*

N. B.—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.

THIS IS A PERMANENT RECORD

