

APR 15 1935

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

Do not use this space.

8288

1. PLACE OF DEATH

County *Lalloway*Registration District No. *104*Township *Julton*Primary Registration District No. *3008*City *Julton*

(No. _____)

St. _____

Ward) _____

2. FULL NAME *Hugh D Winfrey*(a) Residence, No. *Kansas City Mo St.*

(Usual place of abode)

Ward. _____

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *0 yrs. 9 mos. 23 ds.*How long in U. S., if of foreign birth? *0 yrs. 9 mos. 23 ds.*

yrs. mos. ds.

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)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

*62**00**00*

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Ry. Clerk

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) *OK*11. Total time (years) spent in this occupation *OK*

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

Missouri

13. NAME

OK

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

OK

15. MAIDEN NAME

OK

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

OK

17. INFORMANT (ADDRESS)

Hosp Records

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Anatomical Board* DATE _____ 19____

19. UNDERTAKER (ADDRESS)

*J. C. Roberts Columbia Mo*20. FILED *3/19* 19*35*19*35**D. N. Crewe Registrar*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *3-16* 19*35*22. I HEREBY CERTIFY, That I attended deceased from *12-15-* 19*34*, to *3/16* 19*35*I last saw him alive on *3/15* 19*35* Death is saidto have occurred on the date stated above, at *6:17 a.m.*

The principal cause of death and related causes of importance were as follows:

Slow Paralysis of the Insane

Date of onset

Other contributory causes of importance:

*Syphilis*Name of operation *None* Date of _____What test confirmed diagnosis? *Histological* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify _____

(Signed) *Thos Adaphniks* M. D.(Address) *State Hosp. No. 1 Julton, Mo*

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

