

DEC'D MAY 10 1939

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

13931

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Ykaw Primary Registration District No. 100 Registered No. 1685
(c) City W. C. Mo. (d) Street No. General Hospital #2 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

535 Jola Winton
(a) Residence, No. 2019 Park St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 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) 3-11-1919
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
20 10 0

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

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

FATHER 13. NAME Dave Winton
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Okla.

MOTHER 15. MAIDEN NAME Bertha Marie
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Okla.

17. INFORMANT Record Clerk
(ADDRESS) General Hosp.

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Ridge Lam. DATE 4-2 39

19. FUNERAL DIRECTOR West Appt. & Jones
(ADDRESS) City

20. FILED Apr 21 1939 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-11 1939

22. I HEREBY CERTIFY, That I attended deceased from 2-20 1939, to 4-11 1939

I last saw her alive on 4-11 1939 Death is said

to have occurred on the date stated above, at 10/50P m.

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

Chronic Adhesive Pericarditis

Other contributory causes of importance: 90

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? Yes

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? _____

If so, specify _____

(Signed) J. C. Jones M. D.

(Address) General Hospital #2

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)