

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 448 Primary Registration District No. 4266 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Conway Mo
(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 _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME William Winkle
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, Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) _____ (Year) _____

7. Birth date of deceased: June 19 1868
(Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 22 If less than one day _____ hr. _____ min.

9. Birthplace Pulaski County Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____
12. Name Wm Winkle
13. Birthplace East Knoxville
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lillian Todd
(b) Address Lebanon Mo

17. (a) Burial (b) Date thereof 10/12/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lebanon Mo
18. (a) Signature of funeral director W.E. Halman
(b) Address Lebanon, Mo.

19. (a) 11-8-40 (b) G. Wallace Price
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Laclede
(c) City or town Conway
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11 year 1940 hour 3 minute A.M.

21. I hereby certify that I attended the deceased from Oct 2 1940, to Oct 11 1940 that I last saw him alive on Oct 7 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis
Due to _____
Due to 72

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

Duration _____
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? _____

407 (Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature J. C. ...
Address Conway Date signed 11-7-40

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

MOTHER FATHER

RECEIVED

District Health Officer No. 7;

District File Number 11-40-1080

Date Filed 11-12-40

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.....

....., Registered Apprentice No.
working under my personal supervision.

Myself

Signed.....

W. E. Holman

Licensed Embalmer No. 4107

P. O. Address Lebanon Mo

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35-657

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 448

Primary Registration District No. 4266

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Comary
(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 _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME William Krinkle

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 wid

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	Months	Days	If less than one day
<u>77</u>	<u>3</u>	<u>22</u>	hr. _____ min. _____

9. Birthplace Pulaska Co
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

12. Name William Krinkle

13. Birthplace Lebanon Mo
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace Lebanon Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lillian Ford

(b) Address Lebanon Mo

17. (a) _____ (b) Date thereof Oct 12 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lebanon cemetery

18. (a) Signature of funeral director W. E. Halcomb

(b) Address Lebanon Mo

19. (a) 11-8-40 (b) W. E. Halcomb
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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Of autopsy _____

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(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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signat A. L. Danz (M. D. or other) _____

Address Comary Date signed _____

Duration 1 yr

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

APPLIED

