

Registration District No. 663

Primary Registration District No. 5881

1. PLACE OF DEATH:
(a) County Perry
(b) City or town (Rural) St. Mary's Township
(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 _____ (Specify whether)
In this community _____
years, months or days

3. (a) PRINT FULL NAME WILLIAM JOSEPH WINFIELD
3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife ETA M. WINFIELD 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased December 11 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>1</u>	<u>17</u>	hr. min.

9. Birthplace Perry County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name George H. Winfield
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Caroline Furgurson
15. Birthplace Perry County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant ETA M Winfield
(b) Address YOUNT, MO.

17. (a) BURIAL (b) Date thereof JAN 29 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation WHITEWATER CHRISTIAN CEM.

18. (a) Signature of funeral director Perry Funeral Home
(b) Address PERRYVILLE MO.

19. (a) 1-29-41 (b) William Seile
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County PERRY
(c) City or town YOUNT
(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 January day 28th
year 1941 hour 8:30 minute A. M.

21. I hereby certify that I attended the deceased from Jan 1939
1938 to 1941
that I last saw him alive on Jan 9, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Evacuation + exhaustion
Due to Carcinoma of face and neck
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
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? _____

23. Signature Wm H. Bailey, M.D. (M. D. or other) _____
Address Perryville Mo Date signed 29 1941

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

79
00

79
00

52

STATEMENT BY LICENSED EMBALMER

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.

Signed *Le Roy J. Schindler*

Licensed Embalmer No. *4175*

P. O. Address *Perryville, Md.*

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.)

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3752

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 663

Primary Registration District No. 5881

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Perry
(b) City or town Shimons T. P.
(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..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Wm Joseph Winfield

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 M

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 72 Months 1 Days 17 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER, FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (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 Jan day 28 year 1944 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death..... Emaciation and exhaustion Duration

Due to Carcinoma of face and neck
Due to typhus as lymphitis on inner surface of right cheek, duration 3 yrs
Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations..... Of autopsy..... 450

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

23. Signature..... (M. D. or other) Address..... Date signed.....

