

No. 2  
1-4-41  
17-39  
X28390

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(c) Name of hospital or institution: **BARNES HOSPITAL**  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Indiana** (b) County.....  
(c) City or town **North Terre Haute**  
(If outside city or town limits, write "RURAL")  
(d) Street No.....  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Joe Harrison Winders**  
3. (b) If veteran, name war **No.**  
3. (c) Social Security No. **Unknown**

4. Sex **Male** /  
5. Color or race **White**  
6. (a) Single, widowed, married, divorced / **Married**  
6. (b) Name of husband or wife **Edna**  
6. (c) Age of husband or wife if alive **39** years  
7. Birth date of deceased **Feb. 18 1901**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**40** **4** **6** hr. min.

9. Birthplace **Terre Haute / Indiana**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Deputy Sheriff**

11. Industry or business.....

MOTHER FATHER  
12. Name **James M. Winders**  
13. Birthplace **Ohio**  
(City, town, or county) (State or foreign country)  
14. Maiden name **L. Devaun**  
15. Birthplace **Indiana**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Edna Winders**  
(b) Address **N. Terre Haute, Ind.**  
17. (a) **Removal** (b) Date thereof **6/25/41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Terre Haute, Ind.**  
18. (g) Signature of funeral director **Albert H. Hoppe**  
(b) Address **4708 Washington Ave.**  
**JUN 25 1941** (Date received local registrar)  
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **24**  
year **1941** hour **1** minute **20** P.M.  
21. I hereby certify that I attended the deceased from **June 18, 1941** to **June 24, 1941**  
that I last saw him alive on **June 24, 1941**  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Acute myocardial failure** Duration

Due to **Bronchogenic carcinoma of lung with metastasis to mediastinum**

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

Major findings: **Carcinoma of right lung**  
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?

While at work (Specify type of place) (c) Means of injury  
23. Signature **Joe M. Parkin** M. D. **MD**  
Address **BARNES HOSPITAL** Date signed **6-24-41**

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

**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.....

Licensed Embalmer No. 3653

P. O. Address St Louis Mo.

**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.**