

FILED FEB 27 1942

Primary Registration District No. **57358**

Registrar's No. **21**

1. PLACE OF DEATH:
(a) County **Callaway**
(b) City or town **Rural Cedar Trwp**
(c) Name of hospital or institution: **None**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community **About 15 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Callaway**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **5 miles west of New Bloomfield, Mo**
(If rural, give location)
(e) Citizen of foreign country? **()** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Cora Elizebeth Winterowd**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **J. D. Winterowd**
6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **March 6 1889**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	52	10	13	_____ hr. _____ min.

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

10. Usual occupation **House wife**

11. Industry or business _____

MOTHER FATHER
12. Name **Jessie Honlin**
13. Birthplace **Pennsylvania**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Huffman**
15. Birthplace **Pennsylvania**
(City, town, or county) (State or foreign country)

16. (a) Informant **J. D. Winterowd**
(b) Address **New Bloomfield, Mo.**

17. (a) **Burial** (b) Date thereof **L 21 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hopewell**

18. (a) Signature of funeral director **Ray A Holt**
(b) Address **New Bloomfield, Mo**

19. (a) **Jan 19-42** (b) **Josie Manschhoff**
(Date received local registrar) (Registrar's signature)

1177
(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **19**
year **1942** hour **11** minute **40** **PM**

21. I hereby certify that I attended the deceased from **Jan 9 1942** to **Jan 19 1942**
that I last saw him alive on **Jan 14 1942**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic Pneumonia**

Due to _____

Due to _____

Other conditions **General Arthritis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **TV**

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 **E. M. Rusk** (M. D. or other) **TV**
Address **New Bloomfield, Mo** Date signed **1/20 42**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 me

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

Signed Ray Holt
Licensed Embalmer No. 2605
P. O. Address Crews Blomfield

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. 6146

Registration District No. 109

Primary Registration District No. 5158

Registrar's No. _____

1. PLACE OF DEATH: Callaway

(a) County _____

(b) City or town _____
(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)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Cora E. Winterowd

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex <u>F</u>	5. Color or race <u>w</u>	6. (a) Single, widowed, married, divorced. <u>m</u>
6. (b) Name of husband or wife _____		6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased <u>Mar 6 1889</u> (Month) (Day) (Year)		

8. AGE: Years <u>52</u>	Months <u>10</u>	Days <u>19</u>	(If less than one day) _____ min.
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9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry of business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day _____ year 1942 hour _____ minute _____ M.

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

Immediate cause of death _____

Hypostatic Pneumonia
Lobar Pneumonia

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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)

(e) Means of injury _____

23. Signature Daniel Ruck (M. D. or other)

Address _____ Date signed 4/4/42

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

SUPPLEMENTARY

MOTHER FATHER

