

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21022**

FILED JUL 11 1945
Registration District No. **274**

Primary Registration District No. **352**

Registrar's No. **163**

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Bothwell Hospital **1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks (Specify whether years, months or days)

In this community 35 years

3. (a) PRINT FULL NAME Anna Mary Winter

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

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed **2**

6. (b) Name of husband or wife Peter W. Winter 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 25 1863
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>3</u>	<u>1</u>	hr. _____ min. _____

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

10. Usual occupation House Wife

11. Industry or business _____

MOTHER FATHER { 12. Name Christian C. Strueber

13. Birthplace Germany **4**
(City, town, or county) (State or foreign country)

14. Maiden name Paulina Junge

15. Birthplace Germany **4**
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Pauline Bringes

(b) Address St. Louis, Missouri

17. (a) Burial (b) Date thereof June 28, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director McLaughlin Bros.

(b) Address Sedalia, Missouri

19. (a) 6-26-45 (b) Mrs. Anna Meyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis **80**

(c) City or town Sedalia **6**
(If outside city or town limits, write "RURAL")

(d) Street No. 614 Wilkerson
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26th
year 1945 hour 9 minute 25 A. M.

21. I hereby certify that I attended the deceased from over 10 years to 6-26 1945
that I last saw him alive on June 26 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cardio Nephritic (Decompensated) 14 years

Due to arteriosclerosis and edema 60 days

Due to Pericarditis 10 years

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

Major findings:
Of operations none **13/10**

Of autopsy none

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) No

(b) Date of occurrence None

(c) Where did injury occur? None
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? No

While at work _____ (Specify type of place) (e) Means of injury 0

23. Signature J. B. Carlisle M.D. (M. D. or other)
Address Sedalia Mo. Date signed 6-26-45

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

7/9/45

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. _____

2153

P. O. Address _____

Sedalia 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.