

FILED JUL 26 1947

Registration District No.

Primary Registration District No. 45-17

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Taney

(b) City or town Branson
(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 Mo. (b) County: Taney 106

(c) City or town: Branson
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME SHERMAN PORTER WINCH

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14
year 1947 hour 11:00 minute A. M.

21. I hereby certify that I attended the deceased from May 1 1947 to June 14 1947
that I last saw him alive on June 14 1947
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Faune V. Winch 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 30 - 1862
(Month) (Day) (Year)

Immediate cause of death Myocarditis 1 wk.

Due to Semility 6 mo.

8. AGE: Years 84 Months 7 Days 14 If less than one day hr. min.

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

Major findings: _____

Of operations _____

Of autopsy _____

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

10. Usual occupation Justice of Peace

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Calvin Joseph Winch

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

14. Maiden name Phyllis Dorwin Dow Know. 9

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

16. (a) Informant Ira Henderson

(b) Address Branson Mo

17. (a) Buried (b) Date thereof 6-15-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Branson Mo

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? _____

18. (a) Signature of funeral director A. O. Kibele

(b) Address Branson Mo

19. (a) 6-17-47 (b) S.E. Co. S.W. 11
(Data received local registrar) (Registrar's signature) 891

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

23. Signature Harry T. Evans M.D. (M. D. or other) _____
Address Branson Mo Date signed 6/14/47

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

RECEIVED
District Health Officer No. 6,
District File Number 747-788
Date Filed JUN 23 1947

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 Minnie L. Wheelock
Licensed Embalmer 2977
P. O. Address Beaumont, Tex

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 352

Primary Registration District No. 4517

Registrar's No. 10-1

1. PLACE OF DEATH:

(a) County Jarvis
(b) City or town Osanson
(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

Sherman P. Wunch

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 _____

7. Birth date of deceased Oct 30
(Month) (Day) (Year)

8. AGE: Years 84 Months 7 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Ind
(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) _____ (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) 6-17-47 (b) S E Cogswell
(Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day _____
year 1947 hour _____ minute _____ M.

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

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 _____ (M. D. or other)

Address _____ Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

20529