

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33245**

Registration District No. **157**

Primary Registration District No. **1028**

Registrar's No. **242**

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
110 N. Garrison Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 61 years _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME FAYE LEONA WINKLER

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Horace Winkler 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased June 26 1887
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>4</u>	<u>0</u>	_____ hr. _____ min.

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

10. Usual occupation housewife

11. Industry or business at home

12. Name William H. Patterson

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

14. Maiden name Ellen Williams

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

16. (a) Informant Horace Winkler

(b) Address 110 N. Garrison, Carthage, Mo

17. (a) burial (b) Date thereof Oct 29, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sarcoxie Cemetery

18. (a) Signature of funeral director Knell Mortuary

(b) Address Carthage, Missouri

19. (a) 10/25/1948 (b) Dr. B. Clinton, MD
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Carthage
(If outside city or town limits, write "RURAL")
(d) Street No. 110 N. Garrison Ave.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 26
year 1948 hour 11:15 minute _____ a. M.

21. I hereby certify that I attended the deceased from July 26 1948 to Oct 26 1948
that I last saw her alive on Sept 3 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage, pulmonary -
Due to Tuberculosis, pulmonary 1 yr

Other conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none

Duration
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? _____ (X) Means of injury _____
Signature George H. Wood (M. D. or other)
Address Carthage Mo Date signed Oct 26 48

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

MOTHER FATHER

9-300
10-47
17-39
I 3906

FILED NOV 12 1948

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 Robert H. Knell

Licensed Embalmer No. 4459

P. O. Address. Carthage

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.