

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 458

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u>	
c. LENGTH OF STAY (in this place) <u>24 Days</u>		d. STREET ADDRESS (If rural, give location) <u>306 E 2nd St.,</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Callaway Co. Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>John</u>	b. (Middle) <u>D.</u>	c. (Last) <u>Winterowd</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>1 21 49</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 31, 1877</u>	9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) <u>72 0 20</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Hospital Attendant</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>LeGrande, Iowa</u>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <u>J.T.C.</u>	13b. MOTHER'S MAIDEN NAME <u>J.K.</u>	14. NAME OF HUSBAND OR WIFE <u>Cora Elizabeth</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Fred Winterowd</u>	ADDRESS <u>Fulton, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiac Renal Vase Disease</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>114 DX</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>1)</u>
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22. I hereby certify that I attended the deceased from 12/11, 1947, to 1/21, 1949, that I last saw the deceased alive on 1/21, 1949, and that death occurred at 855 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>George F. Wood M.D.</u>	23b. ADDRESS <u>Fulton Mo.</u>	23c. DATE SIGNED <u>1/22/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>Jan. 25, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hope Hill Cem</u>	24d. LOCATION (City, town, or county) (State) <u>New Bloomfield MO</u>
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DATE REC'D BY LOCAL REG <u>Jan 25 1949</u>	REGISTRAR'S SIGNATURE <u>Josie Morsuek Hoff</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wallace Funeral Home</u>	ADDRESS <u>Fulton Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed FEB 1 1949

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 _____
Student Embalmer No. _____
working under my personal supervision.

Student _____
Student Embalmer

Signed Wendell C. Browning
Licensed Embalmer No. 2724
P. O. Address Fallon 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.