

STANDARD CERTIFICATE OF DEATH

State File No. 38548

FILED NOV 29 1951

BIRTH NO.		REG. DIST. NO. 310		PRIMARY REG. DIST. NO. 3058		Registrar's No. 224	
1. PLACE OF DEATH a. COUNTY St Charles				2. USUAL RESIDENCE, (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St Charles			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Charles		c. LENGTH OF STAY (in this place) 9 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Charles		d. STREET ADDRESS (If rural, give location) 836 Nathan	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Joseph Hospital				4. DATE OF DEATH (Month) (Day) (Year) Nov. 16 1951			
3. NAME OF DECEASED (Type or Print) a. (First) Bessie		b. (Middle) E		c. (Last) Winn			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 13 1889	9. AGE (in years last birthday) 62	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house keeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Boone County Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Oscar Rawlings		13b. MOTHER'S MAIDEN NAME Mollie Carson		14. NAME OF HUSBAND OR WIFE James Winn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NO 45		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs S.R. Cox 836 Madison			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage due to ruptured esophageal varix				36 hrs.	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) _____					
		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				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)			
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?			
22. I hereby certify that I attended the deceased from 8-13-49 , 19 49 , to 11-16 , 19 51 , that I last saw the deceased alive on 11-16 , 19 51 , and that death occurred at 5-30 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) [Signature]				23b. ADDRESS 114 N. Main St., St. Charles, Mo.		23c. DATE SIGNED 11-17-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov. 19 1951		24c. NAME OF CEMETERY OR CREMATORY Columbia Cemetery		24d. LOCATION (City, town, or county) (State) Columbia Mo	
DATE REC'D BY LOCAL REG. 11-24-51		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS St. Charles, Mo	

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

970

File No. _____
DISTRICT HEALTH OFFICE No. 4

NOV 26 1951

RECEIVED

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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 Frederic H. Bane

Licensed Embalmer No. 4607

P. O. Address H. Charles, 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.