

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2517

FILED FEB 3 1953

BIRTH NO. _____		REG. DIST. NO. 274		PRIMARY REG. DIST. NO. 5932		Registrar's No. 39	
1. PLACE OF DEATH a. COUNTY Pettis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pettis			
b. CITY (If outside corporate limits, write RURAL and give township) LaMonte		c. LENGTH OF STAY (in this place) 0800		c. CITY (If outside corporate limits, write RURAL and give township) LaMonte		d. STREET ADDRESS (If rural, give location) LaMonte Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION LaMonte Mo							
3. NAME OF DECEASED (Type or Print) a. (First) James		b. (Middle) Franklin		c. (Last) Winkler		4. DATE OF DEATH (Month) 1 (Day) 25 (Year) 1953	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH 4-14-1871	
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and State or Foreign Country) Urbana Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME William Winkler		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Louise J. McAdams Sedalia Mo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Louise J. McAdams Sedalia Mo			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ 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. E9/60 16			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) LaMonte Pettis Mo			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11-15-53 8 PM		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Bulldozer in which he was sleeping burned			
22. I hereby certify that I attended the deceased from _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:58 PM, from the causes and on the date stated above.							
23a. SIGNATURE Chas Gordon Kempfke MD				23b. ADDRESS Cormer, Pettis Co		23c. DATE SIGNED 1-26-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-28-53		24c. NAME OF CEMETERY OR CREMATORY Crown Hill		24d. LOCATION (City, town, or county) (State) Sedalia Mo.	
DATE REC'D BY LOCAL REG. 1-28-1953		REGISTRAR'S SIGNATURE R. G. Campbell MD		FUNDAL DIRECTOR'S SIGNATURE Paul M. Moore		ADDRESS LaMonte Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 11 1954

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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

*Frank M. Moore*

Licensed Embalmer No.

*3923*

P. O. Address

*La Monte 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.