

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24010**  
853  
Registrar's No. \_\_\_\_\_

FILED AUG 10 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Joseph</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Joseph</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>State Hospital no 2</b>		d. STREET ADDRESS (If rural, give location) <b>2324 Farron St.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Elizabeth</b> b. (Middle) <b>T</b> c. (Last) <b>Winston</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Aug 3 1953</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never married</b>	8. DATE OF BIRTH <b>Nov. 14 1915</b>	9. AGE (In years last birthday) <b>77</b>	10. MONTH <b>8</b>	11. DAY <b>19</b>	12. HOUR & MIN. <b>19</b>
10a. USUAL OCCUPATION (Other kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeping</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St Joseph, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13a. FATHER'S NAME <b>Thos. A. Winston</b>	13b. MOTHER'S MAIDEN NAME <b>Hanora Doolay</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Thos. A. Winston</b>	ADDRESS <b>2324 Farron S. Joe Mo.</b>
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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 <b>2 dys.</b>  <b>yrs.</b>  <b>4 yrs.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypostatic Pneumonia</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arterio Sclerosis</b> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <b>Psychosis</b>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4500</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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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?
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22. I hereby certify that I attended the deceased from **Jan 1, 1953, to Aug 3, 1953**, that I last saw the deceased alive on **Aug 2, 1953**, and that death occurred at **4:30 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Thornton Thomas M.D.</b> (Degree or title)	23b. ADDRESS <b>St Joseph Mo. State Hosp No 2</b>	23c. DATE SIGNED <b>8/3/53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Aug 6, 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>St Joseph Mo.</b>
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DATE REC'D BY LOCAL REG. <b>Aug 4, 1953</b>	REGISTRAR'S SIGNATURE <b>Boether M. Allison</b>	4455	25. FUNERAL DIRECTOR'S SIGNATURE <b>Heroman W. Sidenfaden</b>	ADDRESS <b>1802 Union St.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 \_\_\_\_\_

*Robert L. Gaphs*

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.