

FILED OCT 22 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

348388

STATE FILE NUMBER

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 42

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Boone</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Boone</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>TOWN <u>Centralia</u>                     |  | c. CITY OR TOWN <u>Centralia</u> <u>0100</u><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Way Nursing Home</u> |  | Length of stay in 1b <u>4 1/2 mo</u>  |  |
|  |  | d. STREET ADDRESS (If outside, give location)<br><u>329 S. Allen</u>  |  |
|  |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |

|  |                                      |   |  |  |   |
|--|--------------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Minnie</u> Middle <u>Lee</u> Last <u>Winn</u>                          |                                      |   | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>18</u> Year <u>'57</u>     |  |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>Caucasian</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Apr 13 1863</u>                                 | 9. AGE (In years last birthday)<br><u>94</u> | IF UNDER 1 YEAR<br>Months <u>6</u> Days <u>5</u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>        |                                      | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><u>Boone County, Mo.</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                  |
| 13. FATHER'S NAME<br><u>John C. Keithley</u>   |                                      |   | 14. MOTHER'S MAIDEN NAME<br><u>Lucy Mahan</u>                          |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u> |                                      | 16. SOCIAL SECURITY NO.<br><u>no</u>  | 17. INFORMANT<br>Address<br><u>Mrs. John Brink, Centralia, Mo.</u>     |  |   |

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|--|---|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Infermities of Old age</u> |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6, 10, years.</u><br><u>Unknown</u>                        |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <u>Cardio Renal Syndrome</u> |   |
|  | DUE TO (c) <u>Arteriosclerosis</u>      |   |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u></u>                   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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|---|---|--|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u></u> |  |
| 20c. TIME OF INJURY<br>Hour <u></u> Month, Day, Year<br>a. m. <u></u> p. m. <u></u>                       |   |  |

|  |  |   |
|--|--|---|
| 20d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><u></u> | 20f. CITY, TOWN, OR LOCATION<br><u>Centralia</u> COUNTY <u>Mo.</u> STATE <u>Mo.</u> |
| 21. I attended the deceased from <u>6-8-57</u> to <u>10-18-57</u> and last saw <sup>her</sup> <del>him</del> alive on <u>10-15-57</u><br>Death occurred at <u>8:30 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |
| 22a. SIGNATURE<br><u>J. J. Meador</u> (Degree or title)  | 22b. ADDRESS<br><u>Centralia Mo</u>  | 22c. DATE SIGNED<br><u>10-19-57</u>   |

|  |                                 |  |   |
|--|---------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 23b. DATE<br><u>Oct 20, '57</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Horeb</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Centralia Mo.</u> |
|--|---------------------------------|--|---|

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|---|--|--|
| 24. FUNERAL DIRECTOR<br><u>Bill J. Meador</u> ADDRESS <u></u> | 25. DATE RECD. BY LOCAL REG.<br><u>Oct 20 - 1957</u> | 26. REGISTRAR'S SIGNATURE<br><u>Maud McBride</u> |
|---|--|--|

(Licensed Embalmer's Statement on Reverse Side)

Health,  
& Welfare  
Public  
Service300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 .....  
Signature of Student Embalmer

Signed. *Boone Schlanke*

Licensed Embalmer No. *41*  
P. O. Address *Montgomery*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.