

t. Health,  
, & Welfare  
S. Public  
th Service

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v. 1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43147

STATE FILE NUMBER

FILED DEC 16 1957

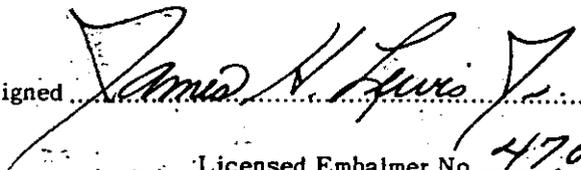
Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 235

1. PLACE OF DEATH a. COUNTY <u>Saline</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Marshall</u> <u>097</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>314 East Rea</u>		Length of stay in lb <u>3 years</u>	d. STREET ADDRESS (If outside, give location) <u>314 East Rea</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine Carroll VanWinkle</u>			4. DATE OF DEATH Month Day Year <u>December 11th 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1871</u>	9. AGE (In years of birthday) <u>86</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (City and state or country) <u>Shackelford Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>E. W. Carroll</u>		13b. MOTHER'S MAIDEN NAME <u>Almira Burnside</u>		14. NAME OF HUSBAND OR WIFE <u>-----</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Melva Akers, Marshall Missouri</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>4221</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility, Malnutrition &amp; dehydration.</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>June 55</u> to <u>12-11-57</u> and last saw <u>her</u> alive on <u>12-18-57</u> . Death occurred at <u>4 P. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Ralph H. Jones M.D.</u> (Degree or title)			22b. ADDRESS <u>Marshall, Mo.</u>		22c. DATE SIGNED <u>12-12-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-14-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Marshall Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Campbell-Lewis, Marshall Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-12-57</u>	26. REGISTRAR'S SIGNATURE <u>Cecil S. Reed</u>		

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  .....

Licensed Embalmer No. 4709  
P. O. Address Marshall, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.