

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35-000377

Health,
Welfare
Public
Service

STATE FILE NUMBER 85

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 85

FILED FEB 2 1959

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1-57

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1701 Savannah Ave.		Length of stay in lb 9 yrs	d. STREET ADDRESS (If outside, give location) 1701 Savannah Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FANNIE C WINSLOW			4. DATE OF DEATH Month Day Year Jan. 17 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3rd, 1869	9. AGE (In years last birthday) 89	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) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Salem Indiana		12. CITIZEN OF WHAT COUNTRY? U S A
13a. FATHER'S NAME Jacob Hattabaugh		13b. MOTHER'S MAIDEN NAME Mary Jane Waddle		14. NAME OF HUSBAND OR WIFE Sanford Winslow (Deceased)	
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. None	17. INFORMANT Mr. Elvin Winslow Address 1701 Savannah Ave. St. Joseph, Mo.		
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>Arricular Fibrillation - acute</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Acute Myocardial Insufficiency</u> DUE TO (c) <u>Senile Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONTRIBUTIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility & Senile Psychosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>48 h.</u> <u>72 h.</u> <u>4221</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 o.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>1951</u> , to <u>1/17/59</u> and last saw her <u>alive</u> on <u>1/16/59</u> Death occurred at <u>6:20 A</u> m./on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>A. Scott Benson M.D.</u> (Degree or title)			22b. ADDRESS <u>324 W. 6th</u>		22c. DATE SIGNED <u>1/19/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7-20-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oregon Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Oregon Missouri</u>
24. FUNERAL DIRECTOR <u>Stamps Funeral Home</u> ADDRESS <u>St. Joseph, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Jan 23 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mr. Clark Goodell</u>

Dr. Scott C. Benson
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed.

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 *Charles E. Bennett*

Licensed Embalmer No. *4677*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.