

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016754
STATE FILE NUMBER

FILED JUN 1 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 238

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157
57

1. PLACE OF DEATH a. COUNTY <u>Boone County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shelby</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Leonard</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>UNIV. Med. Center</u>		Length of stay in lb <u>4 days</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Chester</u> Middle <u>Winget</u> Last <u>Winget</u>			4. DATE OF DEATH Month <u>5</u> - Day <u>24</u> - Year <u>59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/7/89</u>	9. AGE (In years last birthday) <u>70</u>	10. FUNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Shelby Co Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Zy Winget</u>		13b. MOTHER'S MAIDEN NAME <u>Alpha Browning</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>yes World War I</u>		16. SOCIAL SECURITY NO. <u> ?</u>	17. INFORMANT <u>Hospital Record</u> Address		

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>ATALECTASIS, BILATERAL LOWER LOBES</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>EXPLORATORY LAPAROTOMY</u>		<u>3 DAYS</u>
	DUE TO (c) <u>PARALYTIC ILEUS</u>		<u>2 WEEKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>5701</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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 <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u>					

20d. INJURY OCCURRED 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.)	20f. CITY, TOWN, OR LOCATION <u> </u>		COUNTY <u> </u>	STATE <u> </u>
21. I attended the deceased from <u>MAY 20, 1959</u> to <u>MAY 24, 1959</u> and last saw him alive on <u>MAY 24, 1959</u> . -Death occurred at <u>7:00 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>John H. Landon M.D.</u>			22b. ADDRESS <u>807 STADIUM RD.</u>		22c. DATE SIGNED <u>MAY 24, 1959</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 26 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Zion</u>	23d. LOCATION (City, town, or county) (State) <u>Shelby County Mo</u>	
24. GROOMING DIRECTOR <u>Greening Funeral Home Shelbyville</u>		ADDRESS <u>Mo</u>	25. DATE RECD. BY LOCAL REG. <u>May 24 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

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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 *George A. Kurfy*

Licensed Embalmer No. *757*
P. O. Address *Columbia, 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.