

FILED JUN 12 1959

XC-1296410

REG.#15876

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016930

STATE FILE NUMBER

Registration District No. **43**

Primary Registration District No. **2007**

Registrar's No. **265**

300
1-57

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARKANSAS b. COUNTY LAWRENCE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		c. CITY OR TOWN SMITHVILLE	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADM. HOSPITAL		d. STREET ADDRESS (If outside, give location) ROUTE TWO	
Length of stay in lb 54 DAYS		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First WILLIE Middle LEE Last WINTERS			4. DATE OF DEATH Month JUNE Day 1 Year 1959		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-29-96	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	11. BIRTHPLACE (City and state or country) SMITHVILLE, ARKANSAS	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME LEE WINTERS	13b. MOTHER'S MAIDEN NAME MARY WHITLEY	14. NAME OF HUSBAND OR WIFE FLORA WINTERS
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WWI	16. SOCIAL SECURITY NO. 432704810	17. INFORMANT VA HOSPITAL RECORDS, POPLAR BLUFF, MO.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBACUTE BACTERIAL ENDOCARDITIS.		INTERVAL BETWEEN ONSET AND DEATH Several weeks.
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) RHEUMATIC HEART DISEASE, CHRONIC, CONGESTIVE FAILURE. (Years)
	DUE TO (c) CHRONIC LYMPHOCTIC LEUKEMIA.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHRONIC LYMPHOCTIC LEUKEMIA.		19. WAS AUTOPSY PERFORMED? 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 VA	COUNTY	STATE
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21. Attended the deceased from APRIL 7, 1959 to JUNE 1, 1959 Death occurred at 9:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) ROBERT S. COHEN, M.D., Chief, Med. Svc.	22b. ADDRESS VA HOSPITAL, Poplar Bluff, Mo.	22c. DATE SIGNED 6/2/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE 6-3-1959	23c. NAME OF CEMETERY OR CREMATORY Smithville	23d. LOCATION (City, town, or county) Smithville,	(State) Ark.
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24. FUNERAL DIRECTOR Gregg Funeral Home	ADDRESS Walnut Ridge, Ark.	25. DATE RECD. BY LOCAL REG. 6/6/59	26. REGISTRAR'S SIGNATURE R. M. Metree
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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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

Licensed Embalmer No.

P. O. Address

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.