

# BUREAU DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 11 1960

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STATE FILE NUMBER

Registration District No. 261 Primary Registration District No. 3048 Registrar's No. 8

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>Nodaway</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Worth</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Maryville</b>		Length of stay in 1b		c. CITY OR TOWN <b>Sheridan</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Francis Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Andrew</b> Last <b>Winemiller</b>				4. DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>1959</b>						
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3-20-1885</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (City and state or country) <b>Worth County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S.</b>			
13a. FATHER'S NAME <b>Walter Winemiller</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Jane Weaver</b>			14. NAME OF HUSBAND OR WIFE <b>Mildred Maxine Winemiller</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mildred Maxine Winemiller-Sheridan, Mo.</b>				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) <b>Carcinomatosis</b> DUE TO (b) <b>Carcinoma of bladder</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m.		Month, Day, Year _____								
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		COUNTY		STATE	
21. I attended the deceased from <u>7/20/59</u> to <u>12/17/59</u> and last saw her/him alive on <u>12/17/59</u> Death occurred at <u>8:45 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <b>B. S. Gland M.D.</b>				22b. ADDRESS <b>Maryville Mo</b>				22c. DATE SIGNED <b>12/25/59</b>		(State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>12-19-1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sheridan Cemetery</b>		23d. LOCATION (City, town, or county) <b>Sheridan, Missouri</b>				
24. FUNERAL DIRECTOR <b>Paul Dunfee - Grand City, Mo</b>				25. DATE RECD. BY LOCAL REG. <b>1-4-60</b>		26. REGISTRAR'S SIGNATURE <b>Bess Holt</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Bill A. Dunfee

Licensed Embalmer No. 490

P. O. Address Grant City

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.