URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-010039

STATE FILE NUMBER

FILED VS APR 4 1960

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 389

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Joseph
Length of stay in 1b: 48 hrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 1029 Willis Nursing Home - Douglas
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Buchanan
c. CITY OR TOWN: St. Joseph
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 1604 Holman
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Frank Middle: Last: Winn
4. DATE OF DEATH: Month: March Day: 27 Year: 1960
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8/20/90
9. AGE (last birthday): 69
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter
10b. KIND OF BUSINESS OR INDUSTRY: Katz Drugs
11. BIRTHPLACE (City and state or country): Kirksville, Mo
12. CITIZEN OF WHAT COUNTRY: U.S.A
13a. FATHER'S NAME: Richard Winn
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Gertrude Winn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 487-12-8769
17. INFORMANT: Gertrude Winn - Wife Address: 1604 Holman

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma of the Prostate
INTERVAL BETWEEN ONSET AND DEATH: Unk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
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. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 4/9/57, to 3/27/60 and last saw ~~xx~~ him alive on 3/26/60
Death occurred at 4:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): S.E. Meloney M.D.
22b. ADDRESS: Social Welfare Board 10th & Olive, St. Joseph, Mo.
22c. DATE SIGNED: 3/28/60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3/30/60
23c. NAME OF CEMETERY OR CREMATORY: Sunbright
23d. LOCATION (City, town, or county): St. Joseph (State): Mo.
24. FUNERAL DIRECTOR: Beatrice Gray ADDRESS: 812 Pacific
25. DATE RECD. BY LOCAL REG.: March 29, 1960
26. REGISTRAR'S SIGNATURE: Mrs. Clark Hardell

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed John T. Mile

Licensed Embalmer No. 3446

P. O. Address Atchison,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.