

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-029430

FILED VS JUL 26 1960

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 144

ENDED

1. PLACE OF DEATH a. COUNTY <u>Yerwood</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Haskell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Twp</u>		Length of stay in 1b <u>6-20-1958</u>	c. CITY OR TOWN <u>West Plains</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Joseph #3</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>SS. Route</u>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Victoria</u> Last <u>Winton</u>			4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1960</u>	
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-1892</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>13</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>h.w.f.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Stone Co Mo</u>	11. BIRTHPLACE (City and state or country) <u>USA.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>
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13a. FATHER'S NAME <u>Henry Ellinger</u>	13b. MOTHER'S MAIDEN NAME <u>Law Wood</u>	14. NAME OF HUSBAND OR WIFE <u>Jack W. Winton</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>	16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT Address <u>Hosp Record</u>
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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) <u>Brain hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerotic heart disease</u>		
DUE TO (c) <u>General arteriosclerosis</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Brain syndrome</u>		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
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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.)
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>
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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
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21. I attended the deceased from 11-1-59 to 7-16-60 and last saw her/him alive on 7-15-60
Death occurred at 2:45 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>F L Martin M.D.</u>	22b. ADDRESS <u>St Joseph #3</u>	22c. DATE SIGNED <u>7-16-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7-16-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local Cemetery</u>	23d. LOCATION (City, town, or county) <u>West Plains, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Hays Funeral Service, Inc. Nevada, Missouri</u>	25. DATE REC'D BY LOCAL REG. <u>7-18-1960</u>	26. REGISTRAR'S SIGNATURE <u>Arma E. Jerry</u>
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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 Richard I. Griffin

Licensed Embalmer No. 5053

P. O. Address H. Scott,

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.