

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000267

STATE FILE NUMBER

FILED VS JAN 9 1961

Registration District No. 38 Primary Registration District No. 5122 Registrar's No. 6

AMENDED

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Boone</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hallsville</u>			Length of stay in 1b <u>4 years</u>		c. CITY OR TOWN <u>Hallsville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Route 1 Rocky Fork Twp</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Olive</u> Middle <u>Maria</u> Last <u>Winn</u>						4. DATE OF DEATH Month <u>Jan.</u> Day <u>3</u> Year <u>1961</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-27-1880</u>		9. AGE (last birthday) <u>80</u>		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) <u>At home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Boone Co., Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Henry Gibbins</u>				13b. MOTHER'S MAIDEN NAME <u>Mary Gordon</u>				14. NAME OF HUSBAND OR WIFE <u>W.B. Winn</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Glenn Frink, Hallsville, Mo.</u>							
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>Metastasis generalized</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Rectal carcinoma</u>										28 months			
DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Surgical resection 1958 & Roentgen therapy 1959</u>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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>February 8, 1951</u> to <u>January 3, 1961</u> and last saw her <u>alive</u> on <u>December 31, 1960</u> Death occurred at <u>2:45</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>L. Lachance, M.D.</u>						22b. ADDRESS <u>110 W. Sneed - Centralia, Mo.</u>				22c. DATE SIGNED <u>1-4-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-5-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Columbia, Mo.</u>					
24. FUNERAL DIRECTOR <u>Parker Funeral Service, Columbia, Mo.</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Jan 5, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>					

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. Kerby

Licensed Embalmer No. 4752

P. O. Address Calumpis, mp

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.