

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-005930

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 54

AMENDED

FILED VS FEB 20 1961

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Length of stay in 1b <u>60 yrs.</u>	c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>704 Ben Lomond</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>CHRISTIAN</u> Last <u>WINKLER</u>			4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>1961</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</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>3/5/1876</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Burlington Railroad Burlington, Iowa</u>		11. BIRTHPLACE (City and state or country) <u>United States</u>	
13a. FATHER'S NAME <u>Abe Winkler</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Gross</u>		14. NAME OF HUSBAND OR WIFE <u>Margaret Gregory</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. <u>---</u>		17. INFORMANT <u>Mrs. Margaret Gregory, 704 Ben Lomond</u> Address <u>Hannibal, 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>Bronchopneumonia,</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>General debility</u>			<u>2 months</u>
	DUE TO (c) <u>Subdiaphragmatic abscess & duodenal ulcer, hemorrhage</u>			<u>2 months</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Post operative, two months from closure of ruptured duodenal</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (See Cause 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 12-7-60 to 2-8-61 and last saw him alive on 2-8-61
Death occurred at 8:20 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Charles A. High MD.</u>	22b. ADDRESS <u>115 North Fifth St. Hannibal, Missouri</u>	22c. DATE SIGNED <u>2-13-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>2/11/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Hannibal, Missouri</u>
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24. FUNERAL DIRECTOR <u>Jack Selway - Hannibal, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>2/13/61</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Luche by T. L. Lillian</u> <u>Pro. Norman</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

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 me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Jack Melroy

Licensed Embalmer No. 4900

P. O. Address Hannibal

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.