

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-010211

STATE FILE NUMBER

AMENDED

Registration District No. 390 Primary Registration District No. 4441 Registrar's No. \_\_\_\_\_

FILED APR 10 1961

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Randolph</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> COUNTY <u>Randolph</u>                    |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Higbee</u>  |   | Length of stay in 1b<br><u>15 yrs.</u>  | c. CITY OR TOWN <u>Higbee</u><br>Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                               |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Naoma Frances Winn</u>   |   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>3/29/61</u>   |
| 5. SEX<br><u>female</u>   | 6. COLOR OR RACE<br><u>white</u>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3/24/90</u>   |
| 9. AGE (last birthday)<br><u>71</u>   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HR<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><u>Renick, Missouri</u>  |
| 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |   | 13a. FATHER'S NAME<br><u>Henry Slaughter</u>  |  |
| 13b. MOTHER'S MAIDEN NAME<br><u>Asbury</u>  |   | 14. NAME OF HUSBAND OR WIFE<br><u>J. Calvin Winn</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>   |   | 16. SOCIAL SECURITY NO.<br><u>none</u>  | 17. INFORMANT Address<br><u>Mrs. C. Palmatory Higbee, Mo</u>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary infarction</u><br>DUE TO (b) <u>Chronic myocarditis</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>9 months</u><br><u>year.</u>  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>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>Jan 1961</u> to <u>March 61</u> and last saw her <u>alive</u> on <u>March 27, 1961</u><br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>W. H. M. Cornick D.O.</u>  |   | 22b. ADDRESS<br><u>Moberly Mo</u>   | 22c. DATE SIGNED<br><u>3-30-61</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE<br><u>3/31/61</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Myers Chapel Cem.</u>  | 23d. LOCATION (City, town, or county) (State)<br><u>SW of Higbee, Mo.</u>  |
| 24. FUNERAL DIRECTOR<br><u>Marion E. Million</u>  | ADDRESS<br><u>Moberly, Mo.</u>  | 25. DATE RECD. BY LOCAL REG.<br><u>April - 1 - 61</u>   | 26. REGISTRAR'S SIGNATURE<br><u>JOE W BURTON</u>   |

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

ITEM NO. 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

*Marion E. Gillison*

Licensed Embalmer No. 3957

P. O. Address Moberly, Mo.

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.