

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-019658

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 119 Primary Registration District No. 5935 Registrar's No. 21

FILED JUN 3 1963

1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Boeuff Twp.</u>		c. CITY OR TOWN <u>Owensville</u>	
Length of stay in 1b. <u>73 yrs.</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>Farm Home</u>		d. STREET ADDRESS (If outside, give location) <u>Rural Route 1</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First <u>Sophia</u> Middle <u>Louise</u> Last <u>Winter</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1963</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>11-8-1868</u>	9. AGE (last birthday) <u>94</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>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (City and state or country) <u>Feuresville, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Peter Kraenow</u>		13b. MOTHER'S MAIDEN NAME <u>Sophia Tappe</u>	
14. NAME OF HUSBAND OR WIFE <u>John Gottlieb Winter</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Harry Winter Owensville, Mo. Rt. 1</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>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterial Sclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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. (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>1954</u> to <u>5-27-63</u> and last saw her alive on <u>5-24-63</u> Death occurred at <u>6:15 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Charles E. Hume</u> (Degree or title)	22b. ADDRESS <u>General</u>
22c. DATE SIGNED <u>5-27-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>5-28-1963</u>
23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Lutheran Cem.</u>	
23d. LOCATION (City, town, or county) <u>near Drake, Mo.</u>	
24. FUNERAL DIRECTOR <u>Gottenstroeter Funeral Home</u> <u>Owensville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-27-63</u>
26. REGISTRAR'S SIGNATURE <u>Delma Uffelman</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59

10370

20370

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**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

*Melford H. H. Winter*

Licensed Embalmer No. 3838

P. O. Address OWENSVILLE

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.