

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **34300**Registration District No. **144356**Primary Registration District No. **5201**Registrar's No. **11**

1. PLACE OF DEATH:

(a) County **Carroll**
(b) City or town **Rural No. with Lin**
(c) Name of hospital or institution: **/**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **At home**
In this community **62 yrs.**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Emma Bell Winfree**

3. (b) If veteran, name war **No**
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Peter B. Winfree**
6. (c) Age of husband or wife if alive **Dead** years
7. Birth date of deceased **July 2 1864**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 3 21 hr. min.

9. Birthplace **GreenTop** No. **0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER { 12. Name **William H. Gatlin**
13. Birthplace **Mo. 0**
(City, town, or county) (State or foreign country)
14. Maiden name **VanNote**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Appie Winfree**
(b) Address **DeWitt, Mo.**

17. (a) **Burial** (b) Date thereof **10-26-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Evergreen Cemetery**18. (a) Signature of funeral director **Willis-Marshall**(b) Address **Carrollton, Mo.**

19. (a) **Oct 26 1943** (b) **Forster Fisher**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Carroll** **17**
(c) City or town **Rural** **0**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **23**
year **1943** hour **10** minute **00** A.M.

21. I hereby certify that I attended the deceased from **1st** 19 **43** to **Oct 23** 19 **43**
that I last saw her alive on **Oct 21** 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Apoplexy** DurationDue to **Parenchymatous hepatitis with choroid of liver**

Due to

Other conditions **124 ft**
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signature **Wm B. Smith** (M. D. or other) **Wm B**
Address **Boonville, Mo.** Date signed **Oct 26 43**

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 11-6-43

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 Myself

....., Registered Apprentice No.
working under my personal supervision.

Signed R. M. Marshall:

Licensed Embalmer No. 2525

P. O. Address Cincinnati, Ohio

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.