

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29135

State File No. \_\_\_\_\_

FILED OCT 1 1948

Registration District No. 7

Primary Registration District No. 4083

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Carroll  
(b) City or town De Witt  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Charles William Winfrey

3. (b) If veteran, \_\_\_\_\_ name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, 2 divorced Widower

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased February 9 1862  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
86 7 1 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace De Witt Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Peter B. Winfrey

13. Birthplace Virginia  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Hall

15. Birthplace Carroll County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Gene Winfrey

(b) Address De Witt Mo.

17. (a) Burial (b) Date thereof 9/12/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation De Witt Mo.

18. (a) Signature of funeral director J.H. Meyer

(b) Address Bruswick Mo.

19. (a) Sept. 13, 1948 (b) Pearl Koch  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll  
(c) City or town De Witt  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 10  
year 1948 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from Sept 9th 1948  
to Sept 9th 1948  
that I last saw him alive on Sept 9th 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Senile Debility  
Prostate Chronic  
Senility

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

23. Signature Traver C. R. (M. D. or other) \_\_\_\_\_

Address Bruswick Mo. Date signed 11 Sept 48

Duration

unknown  
1 year

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed ..... 9-30-48 .....

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.....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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