

REC'D MAR 4 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

5244

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
(b) Township..... Primary Registration District No. **1003**
(c) City **St. Louis** (d) Street No. **City Hospital No. 1** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

C. 12626

2. PRINT FULL NAME

(a) Residence, No. **Ella Winfield 514**
1034 a Allen 23
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Thomas Winfield**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 14, 1885**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
64 7 21

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. **hwk**
10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Kentucky**13. NAME **James Burt**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **?**15. MAIDEN NAME **Mary Mitchell**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **?**17. INFORMANT **Hosp. Info M. Kent**
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE **City Hospital** DATE **2/25/38**19. FUNERAL DIRECTOR **David Paul Fran**
(ADDRESS) **City Hospital**20. FILED **FEB 23 1938**

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **2/5/38** 1922. I HEREBY CERTIFY, That I attended deceased from **11/28/37** 19..... to **2/5/38** 19.....I last saw h. **her** alive on **2-5/38** 19..... Death is said to have occurred on the date stated above, at **11. a** m.

The principal cause of death and related causes of importance were as follows:

Abscess of sacral region
Chronic myocarditis
cause of abscess unknown

Other contributory causes of importance:

Chronic Cholecystitis
Cholelithiasis

Name of operation **Cholecystectomy** Date of **1-5-38**
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **No**

If so, specify.....
(Signed) **Albert H. Krause** M. D.
(Address) **City Hospital No. 1**

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)