JAN 11 1939

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

701

41012
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 1003
(b) Township ..... Primary Registration District No. ..... Registered No. 10704
or
(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.
D. 13250

2. PRINT FULL NAME 536 Lillian Winters
(a) Residence, No. 1416 Monroe St. 26
(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 (*write* the word) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 9, 1889
7. AGE 49 YEARS MONTHS 1 DAYS 2 If LESS than 1 day, ... hrs. or ..... min.

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. nil
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) Missouri

FATHER
13. NAME John Wilson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ? unknown

MOTHER
15. MAIDEN NAME ? unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ? unknown

17. INFORMANT (ADDRESS) Hosp. Info M.Kent
18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE 12-14-38, 19
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Sullivan 2849 N. Euclid
20. FILED DEC 13 1938 J. P. Biedeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/11/38, 19

22. I HEREBY CERTIFY, That I attended deceased from 12/9/38, 19, to 12/11/38, 19
I last saw her alive on 12/11/38, 19 Death is said to have occurred on the date stated above, at 4.40 m.p
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Nephritis	
Chronic Myocarditis	

Other contributory causes of importance:

Name of operation ..... Date of .....
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? .....
If so, specify .....
(Signed) M. J. Hall, M. D.
(Address) City Hospital No.1

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

50M-9-19-38 I X16605

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 3077 Albert Mayfield, Registered Apprentice No. ....., working under my personal supervision.

Signed Albert Mayfield

Licensed Embalmer No. 3077

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, above space should be left blank.

POWENA MOORE

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

41012
Do not use this space.

1. PLACE OF DEATH
(a) County St Louis — Registration District No. 791
(b) Township — Primary Registration District No. 1003 — Registered No. 10704
(c) City St Louis — (d) Street No. ..... 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.

2. PRINT FULL NAME Lillian Winters
(a) Residence, No. ..... St. ☐ .....
(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): SEPERATED
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: UNKNOWN
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE — YEARS: 49 — MONTHS: 1 — DAYS: 2 — If LESS than 1 day, ... hrs. or ..... min.

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.
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)

FATHER
13. NAME John Wilson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 2-10-39 19 J. F. Bredeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-11, 1938

22. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

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If so, specify .....
(Signed) M. F. Hall, M. D.
(Address) City Hosp No 1

SUPPLEMENTARY

50M-8-5-37 X12241