

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be fully 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

38225

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

Registration District No. 791

Primary Registration District No. \_\_\_\_\_

Registrar's No. 10064

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
3234 A California Ave.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community 15 Years.  
years, months or days)

3. (a) PRINT FULL NAME Frank Wintz

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

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

6. (b) Name of husband or wife Cora Wintz 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Sept 19 1860  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>2</u>	<u>4</u>	hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Rail Road Blacksmith

12. Name Frank Wintz

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

14. Maiden name Anna Weisler

15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Cora Wintz

(b) Address 3234 A California Ave

17. (a) Burial (b) Date thereof Nov 27/39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DeSoto Mo.

18. (a) Signature of funeral director J. Woodruff

(b) Address 2906 Gravois Ave.

19. (a) NOV 25 1939 (b) J. B. Brudeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis. 24  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3234 A California Ave.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? Life. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23  
 year 1939 hour 10 15 P. minutes \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 10-6 1939 to 11-23 1939  
 that I last saw him alive on 11-23 1939  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis with  
arteriosclerosis Duration 5 yrs

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

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

Other conditions Chronic sinusitis  
(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 J. B. Brudeck (M. D. or other) Mo

Address 639 N. Grand Date signed 11/27/39

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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.....

*Thos. Lutus*....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....*Thos. Lutus*.....

Licensed Embalmer No. *1619*.....

P. O. Address *2906 Travis*.....

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.