

FILED MAY 3 1943

Registration District No.

Primary Registration District No. **1003**

Registrar's No. **3843**

1. PLACE OF DEATH:
(a) County.....
(b) City or town..... **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Little Sisters of Poor-3225 N. Florissant**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... **10 Years**
(Specify whether
In this community..... **65 Years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... **Mo** (b) County.....
(c) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3225 N. Florissant Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... **NO** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Tonie Winnie**
3. (b) If veteran, name war.....
3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **23**,
year **1943** hour **3** minute **P.** M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced..... **Single**
6. (b) Name of husband or wife.....
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **May 16 1872**
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
70 11 7 hr. min.

I hereby certify that I attended the deceased from **January 16 1943** to **April 23 1943**
that I last saw him alive on **April 23 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death..... **Chronic Myocarditis**
Duration **8 1/2** Years.
Due to.....
Due to.....

9. Birthplace..... **Italy 5**
(City, town, or county) (State or foreign country)

Other conditions..... **None**
(Include pregnancy within 3 months of death)

10. Usual occupation..... **Rail Road LABORER RETIRED**
11. Industry or business.....
12. Name..... **Tonie Winnie**
13. Birthplace..... **Italy 5**
(City, town, or county) (State or foreign country)
14. Maiden name..... **Annie Angel**
(City, town, or county) (State or foreign country)
15. Birthplace..... **France 5**
(City, town, or county) (State or foreign country)

Major findings:
Of operations..... **None**
Of autopsy..... **None**
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant..... **SISTER WINIFRED**
(b) Address..... **3225 N. FLORISSANT AVE.**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)..... **None**
(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?

17. (a) **BURIAL** (b) Date thereof..... **4-26-43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... **CALVARY CEMETERY**
18. (a) Signature of funeral director..... **Arthur J. Donnelly**
(b) Address..... **2840 Lindell Blvd**
APR 26 1943
19. (a)..... **J. F. Prueck**
(Date received local registrar) (Registrar's signature)

23. Signature..... **Bernard K. Staley** (M. D.)
Address..... **2312 N. 1st St** Date signed..... **4-23-43**

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

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 William Matre

Licensed Embalmer No. 2825

P. O. Address 4370 Lafayette

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.