

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. _____ Primary Registration District No. **1003**

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

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: 4383 Lu
 (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) _____ (Specify whether _____)

3. (a) PRINT FULL NAME HENRY WINTERS

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

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced DIVORCED

6. (b) Name of husband or wife MINNIE 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased ABOUT 1870
 (Month) _____ (Day) 1870 (Year)

8. AGE: Years about 74 Months ? Days ? If less than one day _____ hr. _____ min.

9. Birthplace ST. LOUIS (City, town, or county) MO (State or foreign country)

10. Usual occupation REPAIR MAN

11. Industry or business SELF

12. Name HENRY WINTERS

13. Birthplace ST. LOUIS (City, town, or county) (State or foreign country) 0

14. Maiden name DONT KNOW

15. Birthplace ST. LOUIS (City, town, or county) (State or foreign country) 0

16. (a) Informant MRS. HENRY WINTERS

(b) Address 4539 POPE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 21 1944
 (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director PROVOST UNDER

(b) Address 3710 N. GRAND

19. (a) DEC 24 1944 (b) J. F. Bredack
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000

(c) City or town ST. LOUIS 1710
 (If outside city or town limits, write "RURAL")

(d) Street No. 4283 LEE AVE 1
 (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 21
 year 1944 hour 8 minute 30 PM

21. I hereby certify that I attended the deceased from Nov. 13
Dec. 22 1944 to Dec. 29, 1944
 that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to Valvular Disease

Due to disease

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: zone 92
 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 None

(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 0

23. Signature R. J. Rigler (M. D. or other) 12/25
 Address 415 8th Street Date signed 12/25

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 EARLE PROVOST

Licensed Embalmer No. 1578

P. O. Address 3710 N Grand

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.