

FILED JAN 25 1945 318

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 382

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:
Park Lane Hospital
(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

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. 3019 Whittier
(If rural, give location)

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

3. (a) PRINT FULL NAME Hulda E. Winterfield

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, widowed, married, divorced <u>Married</u>
6. (b) Name of husband or wife <u>August L. Winterfield</u>	6. (c) Age of husband or wife if alive _____ years	
7. Birth date of deceased <u>October 28 1884</u> <small>(Month) (Day) (Year)</small>		

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>2</u>	<u>14</u>	_____ hr. _____ min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER { 12. Name August Summerfield ; U

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

14. Maiden name Maree Loehig

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

16. (a) Informant Richard E. Summerfield

(b) Address 318 Abston

17. (a) Burial (b) Date thereof 1-15-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebanon Cem.

18. (a) Signature of funeral director Drehman Harral

(b) Address 1905 Union Blvd.

19. (a) JAN 15 1945 J. F. Bredock
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 12th
year 1945 hour 11:50 minute P M.

21. I hereby certify that I attended the deceased from 5:30 p.m. 1-12-45 to 11:50 p.m. 1-12-45
that I last saw her alive on 1-12-45, 19____

and that death occurred on the date and hour stated above.

Immediate cause of death Acute intestinal obstruction due to acute strangulated hernia.

Duration _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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)

(c) Means of injury _____

23. Signature [Signature] (M. D. or other) M.D.
Address 4930 Lindell St. Louis Mo. Date signed 1-13-45

Back Issues Sept. 1-4

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..... *Warren A. Carver*

Licensed Embalmer No. *3534*

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, fact should be so stated above.