

No. 2  
-12-45  
5-17-39  
I X47070

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22779

State File No. ....

FILED JUN 30 1947

1003

Registration District No. 318

Primary Registration District No. ....

Registrar's No. 5990

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
3415 Washington  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community Over 25 yrs  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 3415 Washington  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lucy Winston

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex F 5. Color or race Col.

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

6. (b) Name of husband or wife Clarence Winston

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 13  
year 47 hour 10 minute A M.

21. I hereby certify that I attended the deceased from June 6  
1947 to June 6 1947  
that I last saw h. alive on June 5 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia  
Duration

8. AGE: Years Months Days If less than one day  
About 53 hr. min.

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

10. Usual occupation none

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.

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name Jones Jackson

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

14. Maiden name Unknown

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

16. (a) Informant Jessie Winston

(b) Address 3415 Washington

17. (a) Burial (b) Date thereof 6-21-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director A. J. Beal and

(b) Address 2726 Lucas ave

19. (a) J. F. Foredeck  
(Date received by registrar) (Registrar's signature)

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 A. J. Beal (M. D. or other) \_\_\_\_\_

Address 4270 W. Ginney Date signed 6/20/47

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 *Vera Thompson Wilson*

Licensed Embalmer No. *4435*

P. O. Address *4738A Vernon*

**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.**