

FILED AUG 21 1947 318

1003

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

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

1. PLACE OF DEATH:

(c) 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:  
5549 Pershing  
(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 Years  
years, months or days

3. (a) PRINT FULL NAME CHARLES WINETROUB

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 Katherine Winetroub

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased: Jan 20 1885  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

62	6	18	hr. min.
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9. Birthplace Shelbyville Ill  
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Genelle Garment Co.

MOTHER FATHER { 12. Name Wm. Winetroub

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

14. Maiden name Hannah Jackson

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

16. (a) Informant Mrs. Katherine Winetroub

(b) Address 5549 Pershing Ave.

17. (a) Cremation (b) Date thereof Aug 11 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Crematory  
C. Hoffmeister Colonial Mortuary

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address 6464 Chippewa St.

19. (a) AUG 10 1947 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

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

(d) Street No. 5549 Pershing Ave.  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8  
year 1947 hour 4 minute 25 P.M.

21. I hereby certify that I attended the deceased from Sept 1944  
19. to Aug 8 1947 19. 47

that I last saw him alive on Aug 5 19. 47  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration \_\_\_\_\_

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

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

Other conditions Chronic Bronchitis  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

23. Signature A. Walker (M.D. or other) \_\_\_\_\_  
Address 819 Union Club Bldg. Date signed 8-9-47

Dr. Malles  
Univ. Club Bldg.,  
607 No. Grand

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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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Lewis C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broadw*

**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.**