

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 21 1947

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

2695

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:
2839 Cass Avenue
(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 Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2839 Cass Avenue
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Winters

3. (b) If veteran, name war none 3. (c) Social Security No. Unk

4. Sex Male 5. Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Willie Winters 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased January 15, 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 6 24 hr. min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Minerva (Unk)
15. Birthplace Mississippi
(City, town, or county) (State or foreign country)

16. (a) Informant Willie Winters
(b) Address 2839 Cass Ave
17. (a) Removal (b) Date thereof 8/14/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation E. St. Louis, Ill
R. M. C. Green
18. (a) Signature of funeral director _____
(b) Address 3517 Laclede Ave

19. (a) AUG 13 1947 (b) J. P. Budek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9,
year 1947 hour 10 minute 0 M.

21. I hereby certify that I attended the deceased from 1 and 7 Aug to 9 Aug, 1947,
that I last saw him alive on 7 Aug, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy
Hypertension
Due to _____

Due to _____
Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations NO
Of autopsy NO

Duration 7 days

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) (M. D. or other)
23. Signature J. P. Budek Date signed _____
Address _____

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

0. 2
2-45
7-39
X47970

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.....

Melvin E. Green

Licensed Embalmer No. *4428*

P. O. Address..... *St. Louis, Mo.*

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.