

FILED NOV 3 1947

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9628**

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **St. Louis, Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Z. F. Hospital O**
(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)

3. (a) PRINT FULL NAME **Margaretha Winkelmann**

3. (b) If veteran, name war..... **No**
3. (c) Social Security No. **None**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Joseph Winkelmann** 6. (c) Age of husband or wife if alive **dec** years

7. Birth date of deceased **Jan 29 1858**
(Month) (Day) (Year)

8. AGE: Years **89** Months **8** Days **19** hr. min.

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

10. Usual occupation **Housewife**

11. INDUSTRY OR BUSINESS

MOTHER FATHER { 12. Name **John Schwab** **IF**
13. Birthplace **Germany** (State or foreign country) **IF**
14. Maiden name **Anna Ruppert**
15. Birthplace **Germany** (State or foreign country) **IF**

16. (a) Informant **Margaret Winkelmann**
(b) Address **205 May Street**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **10 22 1947**
(Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**
Edward Koch and Son

18. (a) Signature of funeral director.....
(b) Address **2516 N. 14th St**

19. (a) **OCT 20 1947** (Date received local registrar) **J. F. Bredeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **oac**
(c) City or town **St. Louis, Mo** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **9 205 May Street** **9**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **18th**
year **1947** hour **11:30** minute **P.** M.

21. I hereby certify that I attended the deceased from **21**
....., 19....., to....., 19.....;
that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death **Fracture of left hip, arteriosclerosis; when she missed the chair while attempting to sit down and fell to the floor, at her home, on Oct. 7, 1947, about 2:15 P.M.**

ACCIDENT
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) **Accident**
(b) Date of occurrence **10-7-1947**
(c) Where did injury occur? **St. Louis, Mo.**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home

While at work **no** (Specify type of place) (e) Means of injury **see above**

23. Signature **J. F. Taylor** (M. D. or other) **8**
Address **Deputy Coroner** Date signed **10.20.47**

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..... *Ronald Jabuka*

Licensed Embalmer No..... *3917*

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.