

FILED DEC 22 1947
Registration District No. 318

Primary Registration District No. 1003

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:
3031 North Whittier St.
(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 **Henry F. Winter**
3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex **M** Color or race **O** 5. Color or race **W**
6. (a) Single, widowed, married, divorced, **Married**
6. (b) Name of husband or wife **Josephine Winter**
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **May 28 1886**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	60	6	26	hr. min.

9. Birthplace **Mitchell Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business.....
12. Name **Charles Winter**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Charlotte Westermann**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Josephine Winter**
(b) Address **3031 No. Whittier St.**

17. (a) **Burial** (b) Date thereof **12/12/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Sullivan's Funeral Direc.**
(b) Address **2849 N. Euclid Ave.**

19. (a) **DEC 9 - 1947** (b) **J. F. Brebeck**
(Date received local registrar) (Registrar's signature)

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. **3031 North Whittier St.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **9th**
year **1947** hour **1** minute **40 A.M.**

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

Immediate cause of death
Crowning Eclampsia
Pending 1947

Other conditions.....
(Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....
PHYSICIAN
Underline the cause of 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?..... (Specify type of place)
23. Signature **Dr. C. Taylor** (S. D. or other)
Address **1300 Clark** Date signed **12-11-47**

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

MOTHER FATHER

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: Robert L. Brunkner
Licensed Embalmer No. 3553

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.