

#96265

State File No. 4047

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

23  
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY 000	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo. 0		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS 17	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 2437 Lenox Av 3	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.			

3. NAME OF DECEASED (Type or Print)	a. (First) AGNES	b. (Middle) WINKEL	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) May 3rd, 1949
-------------------------------------	---------------------	-----------------------	-----------	--

5. SEX FEMALE	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH JAN. 13-1876	9. AGE (In years last birthday) 73 Yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
------------------	------------------------	---	----------------------------------	---	---------------------------	--------------------------	--------------------------	-------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY own	11. BIRTHPLACE (State or foreign country) Berlin Germany	12. CITIZEN OF WHAT COUNTRY? 4
--	--	---	-----------------------------------

13a. FATHER'S NAME Mk. Conrad	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Henry Winkel
----------------------------------	--------------------------------------	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs Leo Thoma 6927 Selbyburgen	ADDRESS
--	-------------------------	---	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pulmonary embolus		
ANTECEDENT CAUSES	DUE TO (b) Thrombosis left posterior cerebral artery		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) Hypertensive cardiovascular disease		
II. OTHER SIGNIFICANT CONDITIONS	Thrombophlebitis of left femoral		
Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 93d
--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4221
--	--	------------------------------------

22. I hereby certify that I attended the deceased from 4/2/49, 19, to 5/3/49, 19, that I last saw the deceased alive on 5/3/49, 19, and that death occurred at 3:00 PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Deborah W. U.D.C.	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 5/3/49
---	--------------------------------------	----------------------------

24a. BURIAL CREMATION-REMOVAL (Specify) BURIAL	24b. DATE May 6-49	24c. NAME OF CEMETERY OR CREMATORY NEW ST. MARCUS	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
---	-----------------------	--	---

DATE REC'D BY LOCAL REG. MAY 5 1949	REGISTRAR'S SIGNATURE J. B. Laster	25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schur	ADDRESS 3125 Lafayette Av
--	---------------------------------------	---	------------------------------

**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.....

....., Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*John B. Kollman*

Licensed Embalmer No. *4014*

P. O. Address *3125 Duquesne Ave*

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.