

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **25419**
 Registrar's No. **6814**

BIRTH NO. **54092-49** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: rank before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirkwood	
c. LENGTH OF STAY (in this place) 1 day		d. STREET ADDRESS (If rural, give location) RR 12, Box 224E	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Anthony		4. DATE OF DEATH (Month) (Day) (Year) Aug 5, 1949	
3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Infant Wind			4. DATE OF DEATH (Month) (Day) (Year)
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Aug 4, 1949
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 1 IF UNDER 1 YEAR Months Days 1 IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) 0		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Daniel Wind		13b. MOTHER'S MAIDEN NAME Irene Bæthold	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Daniel Wind RR12, Box 224E
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pre-maturation 7 wks gestation ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS 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 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) 159
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? 776X
22. I hereby certify that I attended the deceased from 8-4-49 , to 8-5-49 , that I last saw the deceased alive on 8/5 , 19 49 , and that death occurred at 9 A. m., from the causes and on the date stated above.			
23a. SIGNATURE Kevin W. (unintelligible) (Degree or title)		23b. ADDRESS 752 Leeway Ferry Rd	23c. DATE SIGNED 8/5/49
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 8/5/49	24c. NAME OF CEMETERY OR CREMATORY N Picker Cemetery 24d. LOCATION (City, town, or county) (State) St Louis, Mo.
DATE REC'D BY LOCAL REG. AUG 5 1949		REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS L Ziegenhein & Sons 7027 Gravois

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.

Not embalmed.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

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.