

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2493

FILED JAN 29 1952
BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3059 Registrar's No. 24

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Francois | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Francois | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bonne Terre | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Flat River, 0942 | |
| c. LENGTH OF STAY (in this place) | | d. STREET ADDRESS (If rural, give location) 13 Stone 0 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Bonne Terre Hosp | | | |

| | | | | |
|-------------------------------------|---------------------------|---------------------------|-----------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Augusta | b. (Middle) Agatha | c. (Last) Wind | 4. DATE OF DEATH (Month) (Day) (Year) Jan-18-1952 |
|-------------------------------------|---------------------------|---------------------------|-----------------------|--|

| | | | | | | |
|----------------------|-------------------------------|---|--------------------------------------|---|--|---|
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH June 5, 1877 | 9. AGE (In years last birthday) 74 | IF UNDER 1 YEAR Months 7 Days 13 | IF UNDER 24 HRS. Hours Min. |
|----------------------|-------------------------------|---|--------------------------------------|---|--|---|

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

| | | |
|---------------------------------------|--|---|
| 13a. FATHER'S NAME Edward Heim | 13b. MOTHER'S MAIDEN NAME unknown | 14. NAME OF HUSBAND OR WIFE Charles Wind |
|---------------------------------------|--|---|

| | | |
|--|-------------------------|---|
| 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. Harvey Collar ADDRESS Flat River, Mo |
|--|-------------------------|---|

| | | | |
|---|--|--|----------------------------------|
| 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 | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes mellitus | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio sclerosis 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 checked="" type="checkbox"/> 260x |
|------------------------|----------------------------------|--|

| | | |
|--|--|---|
| 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) |
|--|--|---|

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

22. I hereby certify that I attended the deceased from April 3, 1957, to Jan 18, 1952, that I last saw the deceased alive on Jan 18, 1952, and that death occurred at 10 a m., from the causes and on the date stated above.

| | | |
|---|------------------------------------|---------------------------------|
| 23a. SIGNATURE C. H. Appleberry M.D. (Degree or title) | 23b. ADDRESS Flour River MO | 23c. DATE SIGNED 1-18-52 |
|---|------------------------------------|---------------------------------|

| | | | |
|---|------------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Jan-20-1952 | 24c. NAME OF CEMETERY OR CREMATORY St. Francois Memo Park | 24d. LOCATION (City, town, or county) (State) St. Francois Co. Mo |
|---|------------------------------|--|--|

| | | |
|---|--|--|
| DATE REC'D BY LOCAL REG. Jan. 20, 1952 | REGISTRAR'S SIGNATURE Ethel Reddy 287 | 25. FUNERAL DIRECTOR'S SIGNATURE Sparks F. Home ADDRESS Flat River, Mo |
|---|--|--|

(Licensed) Embalmer's Statement on Reverse Side)

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

OCT 21 1952

APR 12 1952

OCT 26 1952

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 *Murphy L. Spence*

Licensed Embalmer No. *4259*

P. O. Address. *Flat River, 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.