

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24141**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **6051** Registrar's No. **158**

1. PLACE OF DEATH a. COUNTY <b>St Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St Charles</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Rural Rt 2</b> ) c. LENGTH OF STAY (in this place) <b>10 yrs</b>		c. CITY OR TOWN <b>St Charles</b> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Rural Rt2</b>		e. STREET ADDRESS (If rural, give location) <b>Rural Rt 2</b> <b>0920</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Leonard</b>	b. (Middle) <b>W</b>	c. (Last) <b>Winzer</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>July 20 1954</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>March 14 1902</b>	9. AGE (In years last birthday) <b>52</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>2</b>	IF UNDER 24 HRS. Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work denoting most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Egg</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Springfield Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Oscar Winzer</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Schmidt</b>	14. NAME OF HUSBAND OR WIFE <b>Leona Powell Winzer</b>
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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. <b>382-05-8477</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Leona Winzer St Charles</b>
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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, asphyxia, 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) <b>Coronary Thrombosis</b>		<b>1 1/2 hour</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive vascular disease</b> DUE TO (c)		<b>5 years</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Pulmonary fibrosis - bronchiectasis</b>		<b>15 years</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4201</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 **May 19 1947**, to **June 28 1954**, that I last saw the deceased alive on **June 28 1954**, and that death occurred at **7:20 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>G. J. Cauty</b> (Degree or title) <b>H.D.O.</b>	23b. ADDRESS <b>St. Charles, Mo.</b>	23c. DATE SIGNED <b>July 21, 1954</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>July 23 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>	24d. LOCATION (City, town, or county) (State) <b>St Charles Mo</b>
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DATE REC'D BY LOCAL REG. <b>July 21 1954</b>	REGISTRAR'S SIGNATURE <b>Francis Hamilton</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>St Charles Mo</b>
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

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AUG 18 1954

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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.....  
Signature of Student Embalmer

Signed.....  
*Arthur C. Lane*

Licensed Embalmer No. *3145*

P. O. Address *H. Lane*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.