

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32289

FILED SEP 21 1954

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8259**

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 <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis, Mo.</b> )		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>St. Louis,</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		STREET ADDRESS (If rural, give location) <b>4 5952 Victoria</b> <span style="float: right;">2049</span>	
3. NAME OF DECEASED (Type or Print)	a. (First) <b>Wayne</b>	b. (Middle) <b>Orville</b>	c. (Last) <b>VanWinkle</b>
4. DATE OF DEATH	(Month) <b>Sept.</b>	(Day) <b>4.</b>	(Year) <b>1954</b>
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>July 7, 1916</b>
9. AGE (In years last birthday) <b>38</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Rite Point Co.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Hillsboro, Iowa</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Kelly Ray VanWinkle</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Polhas</b>	14. NAME OF HUSBAND OR WIFE <b>Audrey VanWinkle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W. W. 2</b>	16. SOCIAL SECURITY NO. <b>334-07-0057</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Audrey VanWinkle</b> ADDRESS <b>5952 Victoria</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>METASTATIC CARCINOMA</b>		<b>1 Mo.</b>
	*Antecedent Causes Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>CARCINOMA OF Rt. KIDNEY</b> DUE TO (c)		<b>1 Mo.</b>
H. 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 <b>As Above</b>		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)	
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? <b>180X</b>	
22. I hereby certify that I attended the deceased from <b>Aug 5, 1954</b> , to <b>SEPT. 4, 1954</b> , that I last saw the deceased alive on <b>SEPT. 4, 1954</b> , and that death occurred at <b>1:10 p.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Robert E. Koch</b>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>3501 CENTRAL</b>	23c. DATE SIGNED <b>9-4-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>9-4-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	24d. LOCATION (City, town, or county) (State) <b>Fort Madison, Iowa</b>
DATE REC'D BY LOCAL REG. <b>SEP 7 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe 4700 Washington</b>	

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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..... *Paul Q. Wachter*

Licensed Embalmer No. *478*

P. O. Address *Howe*

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.