

Health, Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 25 1957

STATE FILE NUMBER **6781**  
**1039**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1039**

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, give TOWNSHIP only) OR TOWN <b>St. Louis</b> ,			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> ,			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3329 Nebraska Ave.</b>			Length of stay in lb <b>01</b>	d. STREET ADDRESS <b>3329 Nebraska Ave.</b>			(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>George</b>				First	Middle	Last	4. DATE OF DEATH <b>January 31, 1957</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 28, 1884</b>		9. AGE (In years last birthday) <b>72</b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired 6 Years</b>		11. BIRTHPLACE (City and state or country) <b>Hillsboro, Missouri</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Matthew Wynn</b>				14. MOTHER'S MAIDEN NAME <b>Lena Moore</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>492-05-0268</b>		17. INFORMANT Address <b>Johanna Wynn, 3329 Nebraska Ave., Wife</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <b>Chronic Valvular Heart Disease &amp; Decompensated</b>					4-5 years				
			DUE TO (c) <b>Asthmatic Bronchitis</b>					4-5 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.												
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION			COUNTY		STATE	
21. I attended the deceased from <b>Feb 1952</b> to <b>1/31/57</b> and last saw her/him alive on <b>1/29/57</b> Death occurred at <b>12:30 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE <b>Dr Paul W. Hulbert M.D.</b>				(Degree or title)	22b. ADDRESS <b>2905 Cherokee - Springfield</b>				22c. DATE SIGNED <b>2/1/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			23b. DATE <b>2/4/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery,</b>			23d. LOCATION (City, town, or county) <b>LeMay, Mo.</b>			(State)		
24. FUNERAL DIRECTOR <b>Gebken-Benz Mortuary,</b>				ADDRESS <b>2842 Meramec St., St. Louis, 18, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 1 '57</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>				

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 me....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Lester C. Pennington.....

Licensed Embalmer No. 4094

P. O. Address St. Louis..

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.