

FILED APR 12 1957

STANDARD CERTIFICATE OF DEATH

318

1003

STATE FILE NUMBER 11886 2253

Registration District No. Primary Registration District No. Registrar's No.

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

| | | | | | | | |
|---|--|--|---|---|--------|---|-------|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP, only) OR TOWN Saint Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Saint Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Pacific Hosp. Life 2039 | | | | Length of stay in 1b | | STREET ADDRESS (If outside, give location) 6441 Mc Cune Ave | |
| 3. NAME OF DECEASED (Type or print) First MIDDLE LAST JAMES E. WYNN | | | | 4. DATE OF DEATH Month Day Year March 5th, 1957 | | | |
| 5. SEX Male 0 | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Mar. 2nd, 1889 | |
| 9. AGE (In years last birthday) 68 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policeman | | 10b. KIND OF BUSINESS OR INDUSTRY City of St. Louis St. Louis, Missouri | | 11. BIRTHPLACE (City and state or country) O | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME William J. Wynn | | | | 14. MOTHER'S MAIDEN NAME Mary Beischer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. World War # 1 | | 17. INFORMANT Mrs. Lena S. Wynn, 6441 Mc Cune Ave | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) Myocardial Infarction with mural thrombus / wk | | | | Many years | |
| | | DUE TO (c) Arteriosclerotic Heart Disease | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac De-compensation - Adenocarcinoma of Prostate | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.) 420.0H | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year 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 Sept 1953 to March 5 1957 and last saw her alive on March 5 1957 Death occurred at 9:00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE Claude E. Hasto MD | | | | 22b. ADDRESS 4909 Lindenwood | | 22c. DATE SIGNED 3/6/57 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATOR | | 23d. LOCATION (City, town, or county) (State) | |
| Removal - Rail | | 3/7/57 | | City Cemetery | | Scottsville, Kentucky | |
| 24. FUNERAL DIRECTOR CALVIN F. FEUTZ, 4828 Natural Bridge FUNERAL HOME, INC., St. Louis, 15, Mo | | | | 25. DATE RECD. BY LOCAL REG. MAR 6 '57 | | 26. REGISTRAR'S SIGNATURE Carl Smith MD | |

HOURS. 1:00P. M. to 3:00 P. M.
File in City

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 *Ralph C. Linder*

Licensed Embalmer No. *42*

P. O. Address *St. Louis*

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.