

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26715

FILED JUL 16 1957

Registration District No. **318** Primary Registration District No. **1003** STATE FILE NUMBER **5153** Registrar's No.

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Jennings		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Length of stay in lb 2 days		d. STREET ADDRESS 9834 Jacobi Dr.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bernice Middle Windmann Last Windmann				4. DATE OF DEATH Month May Day 31 Year 1957			
5. SEX Female	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 Feb. 14, 1923		9. AGE (In years last birthday) 34	IF UNDER 1 YEAR Months 34 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) St. Charles, County, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank Niewig				14. MOTHER'S MAIDEN NAME Hilda Schroer			
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. None		17. INFORMANT Address Wilbert Windmann, 9834 Jacobi Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Glomerular Nephritis. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Collagen Disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 2 yrs.
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.) 456x				
20c. TIME OF INJURY Hour 5:45 AM 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 St. Louis, Mo.		COUNTY STATE	
21. I attended the deceased from 11-7-55 to 5-31-57 and last saw her ^{her} alive on 5-30-57 Death occurred at 5:45 AM on the date stated above; and to the best of my knowledge, from the causes stated.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
22a. SIGNATURE R. Engleman M.D. (Degree or title)				22b. ADDRESS St. Louis, Mo.		22c. DATE SIGNED 5/31/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5-31-57	23c. NAME OF CEMETERY OR CREMATORY City Cemetery		23d. LOCATION (City, town, or county) (State) Warrenton, Mo.		
24. FUNERAL DIRECTOR ADDRESS F.W. Nieburg, Warrenton, Mo.				25. DATE RECD. BY LOCAL REG. JUN 1 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith - MD	

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 *J. W. M. Bunkley*
Licensed Embalmer No. *365*
P. O. Address *J. Hear*

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.