

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011529  
STATE FILE NUMBER  
2037

FILED MAR 9 1959

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registration No. \_\_\_\_\_

S. 300  
1-57  
6  
46  
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>5408 S Bdway</u>	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Esta Winge</u>			4. DATE OF DEATH Month Day Year <u>Feb. 25, 1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/17/81</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>77</u>
11. BIRTHPLACE (City and state or country) <u>Madison County, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Charles Heffley</u>		13b. MOTHER'S MAIDEN NAME <u>Delia Cartzdafner</u>	14. NAME OF HUSBAND OR WIFE <u>Oscar Winge</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk</u>	17. INFORMANT Address <u>St. Louis Altenheim 5408 S Bdway</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>As a result of laceration due to laceration of wrists and throat.</u> DUE TO (b) <u>E 977X</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>self inflicted in prison at St. Louis Prison 5408 South Broadway on February 22, 1959.</u>			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>self inflicted in prison at St. Louis Prison 5408 South Broadway on February 22, 1959.</u>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. <u>2 22 59</u> p.m. <u>22 1959</u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, rest, office bldg., etc.) <u>Home</u>
20f. CITY, TOWN, OR LOCATION <u>St. Louis Mo</u>		COUNTY STATE	
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at <u>9:15 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree of physician) <u>John M. Queen</u>		22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>2/26/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2/27/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Edward Fendler 5611 South Grand Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 26 '59</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith. M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Secretary, coroner, etc.: must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Wesley F. Koeller Jr.* .....

Licensed Embalmer No. *4950* .....

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.