

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015979

STATE FILE NUMBER

Registration District No. 23289

FILED APR 20 1959

Registration District No.

Primary Registration District No.

Registration No.

300
-57
3
191
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>
c. FULL NAME OF (NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Barnes Hospital 2 wks</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>5419 Winona</i>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>Winchell</i> Last			4. DATE OF DEATH Month <i>4</i> Day <i>1</i> Year <i>59</i>			
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5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/14/1892</i>	9. AGE (In years last birthday) <i>66</i>	IF UNDER 24 HRS Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>taxi owner</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>self</i>	11. BIRTHPLACE (City and state or country) <i>Hungary</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>George Winchell</i>	13. MOTHER'S MAIDEN NAME <i>Catherine Tittl</i>	14. NAME OF HUSBAND OR WIFE <i>Leona</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO. <i>494-38-8876</i>	17. INFORMANT Address <i>Mrs. Leona Winchell, 5419 Winona</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH <i>3 DAYS</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CARCINOMA OF BLADDER - PRIMARY SITE		<i>1 YR.</i>
DUE TO (c) OTHER: BACTREMIA DUE TO STAPHOLOCCUS, HEMOLYTIC		<i>4 DAYS</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>181.0</i>		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <i>1:45</i> Month <i>4</i> Day <i>1</i> Year <i>59</i> a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> AT WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <i>St. Louis</i>	COUNTY	STATE
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21. I attended the deceased from <i>FEB. 15, 1959</i> to <i>APRIL 1, 1959</i> and last saw her/him alive on <i>APRIL 1, 1959</i> Death occurred at <i>1:45 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Carl A. Wettersburg M.D.</i>	(Degree or title)	22b. ADDRESS <i>3720 Washington Ave</i>	22c. DATE SIGNED <i>4-1-59</i>

23. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>4/3/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis</i>
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24. FUNERAL DIRECTOR <i>Jos. A. Howard</i>	ADDRESS <i>1619 So. Grand</i>	25. DATE RECD. BY LOCAL REG. <i>APR 2 '59</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Harvey Kable*

Licensed Embalmer No. *4576*
P. O. Address *St. Louis, Mo.*

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.