

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015984

STATE FILE NO. 2 3587

FILED MAY 12 1959

Registration District No. Primary Registration District No.

300

-57

72
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1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.			Length of stay in lb 2 yrs.		d. STREET ADDRESS 1738a Preston Pl.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) BEATRICE Jessie Wintering				4. DATE OF DEATH Month Day Year 4-9-59									
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 16 1887		9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintainance			10b. KIND OF BUSINESS OR INDUSTRY City Hosp		11. BIRTHPLACE (City and state or country) XMAS. England			12. CITIZEN OF WHAT COUNTRY? USA					
13a. FATHER'S NAME Thomas Gladden				13b. MOTHER'S MAIDEN NAME Elizabeth Unknown				14. NAME OF HUSBAND OR WIFE -- Rudolph P. Wintering					
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. ---		17. INFORMANT Address Mary Sullivan 1738 Preston Pl							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Basine Congestion of the Heart</i>										INTERVAL BETWEEN ONSET AND DEATH <i>5 days.</i>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic Heart Disease</i>										<i>2 yrs.</i>			
DUE TO (c) <i>Generalized Arteriosclerosis</i>										<i>2 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										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.) <i>420.0</i>										
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.													
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <i>3-4-57</i> to <i>4-9-59</i> and last saw her alive on <i>4-9-59</i> Death occurred at <i>2:25 p.m.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>John W. Beckham, M.D.</i>						22b. ADDRESS <i>5800 Arsenal</i>			22c. DATE SIGNED <i>4/10/59</i>				
23a. BURIAL, CREMATION, REMOVAL (specify) <i>Burial</i>		23b. DATE <i>Apr 11 59</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SS Peter & Paul</i>				23d. LOCATION (City, town, or county) (State) <i>St. Louis Mo</i>					
24. FUNERAL DIRECTOR ADDRESS <i>E.J. Schnur 3125 Lafayette</i>				25. DATE RECD. BY LOCAL REG. <i>APR 10 59</i>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>							

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 *Thomas R. Fenwick*

Licensed Embalmer No. *3793*
P. O. Address *3125 Lafayette*

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.