URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 15 1959

59–034507

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 9111

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST LOUIS
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 3929 MERAMEC
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN: ST LOUIS
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3929 MERAMEC
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: MATHILDA Middle: Last: WINKEL

4. DATE OF DEATH: Month: OCT. Day: 2, Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: JAN 30, 1875

9. AGE (last birthday): 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): RED BUD, ILL.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: WILLIAM RATHERT

13b. MOTHER'S MAIDEN NAME: MARIE ROEHMER

14. NAME OF HUSBAND OR WIFE

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: VAL H WINKEL Address: 1253 CHARLANE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Arteriosclerotic CVR Dis — 15 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Senile Changes 420.1

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 Feb 1 1959, to Oct 2 1959 and last saw her alive on Sept 22 1959
Death occurred at 4:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Charles A Nester MD

22b. ADDRESS: 5600 S Compton

22c. DATE SIGNED: 10-3-59

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: 10/5/59

23c. NAME OF CEMETERY OR CREMATORY: SUNSET BURIAL PARK

23d. LOCATION (City, town, or county) (State): AFFTON Mo.

24. FUNERAL DIRECTOR: JOHN L ZIEGNHEIN & SONS ADDRESS: 7027 GRAVOIS

25. DATE RECD. BY LOCAL REG.: OCT 5 '59

26. REGISTRAR'S SIGNATURE: Earl Smith. M.D. mdc

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DOCUMENT

Joseph M Carter
Deputy 5-59
10-

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed E. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Grav

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.