

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS NOV 16 1959

59-042727

2,9525

STATE FILE NUMBER

Registration District No. _____		Primary Registration District No. _____		Registrar's No. <b>2,9525</b>		STATE FILE NUMBER	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>1 wk.</b>		c. CITY OR TOWN <b>Rock Hill</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cardinal Glennon Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>832 Manitou Dr.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>MELISSA WINSOTT</b>				4. DATE OF DEATH Month Day Year <b>10 16 1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7-25-1954</b>	9. AGE (last birthday) <b>4 5</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Raymond J. Winscott</b>			13b. MOTHER'S MAIDEN NAME <b>Mildred L. Riffel</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Rock Hill, Missouri</b> <b>Raymond J. Winscott, 832 Manitou Dr.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY HYPERTENSION</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ATRIOVENTRICULARIS COMMUNIS</b>							<b>5 yrs</b>
DUE TO (c) <b>CONGENITAL HEART DISEASE</b>							<b>5 + yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>POST-OPERATIVE COMPLICATIONS - HEART OPERATION</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)					
20c. TIME OF INJURY Hour 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		COUNTY STATE	
21. I attended the deceased from <b>10-8-59</b> to <b>10-16-59</b> and last saw her alive on <b>10-16-59</b> . Death occurred at <b>7:18 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>C. Pellum Haulen M.D.</b> (Degree or title)				22b. ADDRESS <b>1325 S. GRAND BLVD.</b>		22c. DATE SIGNED <b>10-16-59.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-19-1959</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Moberly, Missouri</b>			
24. FUNERAL DIRECTOR <b>Pfztinger Mort. Kirkwood 22, Mo.</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>OCT 17 '59</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b> <i>m g b.</i>		

ENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*Herbert J. San Jr*

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22

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.