

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-042730**

**FILED VS NOV 16 1959**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 9567**

MAILED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</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>2 days</b>	c. CITY OR TOWN <b>Jennings</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>Mo. Baptist Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8320 Mayfair</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Winter</b> Last <b>Winter</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>17</b> Year <b>1959</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/1/1877</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	11. BIRTHPLACE (City and state or country) <b>Grantfork Ill.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Winter</b>		13b. MOTHER'S MAIDEN NAME <b>not known</b>		14. NAME OF HUSBAND OR WIFE <b>Harry C. Winter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Genevieve Larkin 1920 McLaren</b> Address _____		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH <b>10-12-59</b>
IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Atherosclerosis Heart</b>	DUE TO (c) <b>diabetic decompensation</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>260x</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	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20. 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.) <b>260x</b>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>June 1955</b> to <b>Oct 17, 1959</b> and last saw her/him alive on <b>Oct 17, 1959</b> Death occurred at <b>7:45 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			

22. SIGNATURE (Degree or title) <b>Joseph C. Carney MD</b>		22b. ADDRESS <b>906 Olive St</b>		22c. DATE SIGNED <b>10-19-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>10-20-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis</b>	(State) <b>Mo.</b>

24. FUNERAL DIRECTOR <b>Buchholz Mortuary</b>	ADDRESS <b>5967 W. Florissant Av.</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 19 59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 Wilfred S. Buckner

Licensed Embalmer No. 4551

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.