

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b	c. CITY OR TOWN ST. LOUIS, MO
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1420 A. MISSISSIPPI
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last FRANK WINGERTER			4. DATE OF DEATH Month Day Year II/19/60		
5. SEX MALE	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 1/2 8/19	9. AGE (last birthday) 81	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) ??		10b. KIND OF BUSINESS OR INDUSTRY ??		11. BIRTHPLACE (City and state or country) IOWA	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO NO	16. SOCIAL SECURITY NO. ??	17. INFORMANT ST. LOUIS, MO., City Hospital Records	Address
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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:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>aspiration</i>			
DUE TO (b) <i>subarachnoid hemorrhage</i>			
DUE TO (c) <i>330 K</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (a) <i>dehydration + hypotatic pneumonia</i>			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 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.)
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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 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
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21. I attended the deceased from II/13/60 to II/19/60 and last saw her/him alive on II/19/60
 Death occurred at II:45 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Dilany Linder MD</i>	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED II/19/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-29-60	23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	23d. LOCATION (City, town, or county) St. Louis, Mo.
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24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. NOV 29 1960	26. REGISTRAR'S SIGNATURE <i>Loed Smith. M.D.</i>
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Not Embalmed
Lawrence J. Mc
Licensed Embalmer No. _____

P. O. Address _____

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