

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

20054

1. PLACE OF DEATH

County..... Registration District No. **791**

Township..... Primary Registration District No. **1003**

City *St. Louis Mo* (No. *2249 Warren St*)

File No.....

Registered No. **5715**

St. Ward)

2. FULL NAME *Albert H. Winkelmann*

(a) Residence. No. *2249 Warren St* St. *20* Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Gertrude Winkelmann</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>April 17 - 1890</i>		
7. AGE	YEARS	MONTHS
	<i>39</i>	<i>1</i>
		DAYS
		<i>6</i>
		If LESS than 1 day,hrs. ormin.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Trucker*

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *Ills.*
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <i>Jacob Winkelmann</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Ills.</i>
	12. MAIDEN NAME OF MOTHER <i>Catherin Jansen</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Ills.</i>

14. INFORMANT *Gertrude Winkelmann*
(Address) *2249 Warren St.*

15. FILED *MAY 24 1929* *Max C. Starkoff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 23 19 29*

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at *240 A.M.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
95c

CONTRIBUTORY (SECONDARY) *9MB*
(duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY *yes*

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) *J. W. Kemmer M.D.*

512 19 (Address) *St. Coron*
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Zions* DATE OF BURIAL *May 25 19 29*

20. UNDERTAKER *By Leidner Mnd Co. St. Market*
ADDRESS *1417*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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