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

Do not use this space.

31968

File No. 8997

Registered No.

1. PLACE OF DEATH

County

Township

City St Louis Mo (No. 5768 Westminster St. Ward)

Registration District No. 791

Primary Registration District No. 1003

2. FULL NAME Ben Winters

(a) Residence. No. 5768 Westminster St. Pl 5 Ward.
(Usual place of abode)

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M.	W.	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sadie B. Sternberg

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 27, 1868

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
6 p	7	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Cleveland
(STATE OR COUNTRY) Ohio

PARENTS

10. NAME OF FATHER Max Winters

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Sarah Gunter

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Cleveland Ohio

14. INFORMANT Sadie B. Winters
(Address) 5768 Westminster

15. FILED FEB 1 1929 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 5 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 1927, to Sept 5, 1929 that I last saw him alive on Sept 5, 1929, and that death occurred, on the date stated above, at 3:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Cardiac Decompensation
131
93 C
95 C (duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Myocarditis Chronic
Nephritis, Chronic (duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Herman M. Meyer, M. D.

9/5, 1929 (Address) 601 Metropolitan Bldg

*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	DATE OF BURIAL
Mt Sinai	9/6 1929
20. UNDERTAKER	**ADDRESS**
Mayer	4356 Lindell

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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