

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

Do not use this space.

14626

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. 4416 S. Compton Avenue St. _____ Ward)

File No. _____
 Registered No. 4002

2. FULL NAME

John H. Winkelmann
 (a) Residence. No. 4416 S. Compton Ave St. 15 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 Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Barbara Winkelmann				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 22, 1859.				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
	71	--	27	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work. Book-keeper.				
(b) General nature of industry, business, or establishment in which employed (or employer)				
(c) Name of employer				

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

PARENTS	10. NAME OF FATHER Jacob Winkelmann.
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) Germany.
	12. MAIDEN NAME OF MOTHER Caroline Schwaab.
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) Germany.

14. INFORMANT.....
 (Address) **Mrs Mrs Fay 4416 S. Compton Avenue.**

15. FILED.....
 APR 22 1930
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 19 1930**
 17. I HEREBY CERTIFY, That I attended deceased from **March 8 1930**, to **April 19 1930**, that I last saw him alive on **April 19 1930**, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Endocarditis
Chronic Interstitial Nephritis
 (duration) **5** yrs. mos. ds.
 CONTRIBUTORY **Acute Cardiac Dilatation**
 (SECONDARY) (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?.....
 WHAT TEST CONFIRMED DIAGNOSIS? **Physical Exam.**
 (Signed) **Adam G. Gougeon, M. D.**

H/M 1930 (Address) **54 39 Grand**

*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.....
SS. Peter & Paul Cemetery **Apr. 23, 1930**

20. UNDERTAKER..... ADDRESS.....
W. H. Gibson & Co. **2842 Meramec**

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

K. 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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10th Fl

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H/M

