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

Do not use this space.

28271

File No. 8120

Registered No.

1. PLACE OF DEATH

County ..... Registration District No. 791

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

City St. Louis, Mo. (No. 3936 S. Compton St. Ward)

2. FULL NAME Wm. G. Winter

(a) Residence. No. 3936 S. Compton St., 16 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)
Male	White	Widowed

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF (Late) Phlomena Winter.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
About 73			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Machinist.
(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 Geo. Winter

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

12. MAIDEN NAME OF MOTHER Ely Kern

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

14. INFORMANT Laura Winter
(Address) 3936 S. Compton St.

15. FILED AUG 14 1930 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 13, 1930

17. I HEREBY CERTIFY, That I attended deceased from July 2nd, 1930, to Aug. 11th, 1930, that I last saw him alive on Aug. 11th, 1930, and that death occurred, on the date stated above, at 2:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (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?

(Signed) S. H. Steinmann, M. D.

Aug. 13, 1930 (Address) 3108 Chippewa St.

*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 Chillicothe, Ohio.

DATE OF BURIAL 8/15 1930

20. UNDERTAKER Southern

ADDRESS 6320 S. Grand.

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.