

FILED MAY 9 1944

State File No. ....

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3885**

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
BARNES HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 Weeks  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME MAUDE BERNICE WINSTON

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased July 25 1917  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	26	9	0	- hr. - min.

9. Birthplace East St. Louis, Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

12. Name Robert Joseph Winston

13. Birthplace McKenzie, Tennessee  
(City, town, or county) (State or foreign country)

14. Maiden name Maudie Ginther

15. Birthplace Bone Gape, Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ray Winston

(b) Address East St. Louis, Illinois

17. (a) Removal (b) Date thereof 7/26/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director John H. Hasty

(b) Address 1101 N. 9th, E. St. Louis

19. (a) APR 26 1944 (b) J. F. Brudeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St. Clair  
(c) City or town East St. Louis, Illinois  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1362 North 43rd St.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25  
year 1944 hour 11 minute 30 a. M.

21. I hereby certify that I attended the deceased from April 14, 1944 to April 25, 1944  
that I last saw her alive on April 25, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Tuberculin toxicity Duration 2 days

Due to Thoracic plasty revision 2 days

Due to Pulm. tuberculosis 3 years

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations James Shaw

Of autopsy None

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify).....
- (b) Date of occurrence.....
- (c) Where did injury occur?..... (City or town) (County) (State)
- (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature Olga C. Schubert, M.D. (M. D. or other)

Address BARNES HOSPITAL Date signed 4/25/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

2  
3  
39  
37823

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

*not embalmed*

Signed.....

*John J. Kossly*

Licensed Embalmer No. *100-6855*

P. O. Address. *St. Louis, Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**