

FILED JUN 7 1945
Registration District No. **377**

Primary Registration District No. **6076**

1600
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Koch**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Robt Koch Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **222 days**
(Specify whether
In this community **222 days**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **— 17**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4501 Mary**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

ELEANOR VIRGINIA WINN

3. (b) If veteran, name war

3. (c) Social Security No. **493-20-7717**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife **Harry Winn** 6. (c) Age of husband or wife if alive **—** years
7. Birth date of deceased **Aug 3 1925**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
19 9 13 hr. min.

9. Birthplace **St. Louis MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business

MOTHER FATHER

12. Name **Ira Fisher**
13. Birthplace **St. Louis MO**
(City, town, or county) (State or foreign country)
14. Maiden name **Dorothy Fenton**
15. Birthplace **St. Louis MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Hospital Records**

(b) Address **Burial**

17. (a) (Burial, cremation, or removal) (b) Date thereof **5/19/45**
(Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Math. Hermann & Son**

(b) Address **2161 East Fair Avenue**

19. (a) **MAY 21 1945** (Date received local registrar) (b) **E. G. Hansen** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **16** year **1945** hour **5** minute **07 A.M.**

21. I hereby certify that I attended the deceased from **Oct 6 1944** to **May 16 1945**; that I last saw her alive on **May 16 1945**; and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis 1 1/2 yrs?**

Due to **136**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Of autopsy

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) (Specify means of injury)

23. Signature **Ira Fisher** (M. D. or other) **M.D.**

Address **Robt Koch Hosp Koch Mo** Name signed **5-18-45**

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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.

Signed *William G. Burkholz*
Licensed Embalmer No. *2160*
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.