5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED APR 16 1948

State File No. 14453

Registration District No. 377 — Primary Registration District No. 6076 — Registrar's No. 821

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: Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 603 days (Specify whether years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ~~St. Louis~~

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1403 N. 11th Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME NELSON WINSLOW

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race negro

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 January (Month) 20 (Day) 1929 (Year)

8. AGE: Years 17 | Months 2 | Days 13 | If less than one day hr. min.

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

10. Usual occupation Porter

11. Industry or business

FATHER
12. Name Nathan Lee Winslow
13. Birthplace (City, town, or county) Arkansas (State or foreign country)

MOTHER
14. Maiden name Edna Winslow
15. Birthplace Helena (City, town, or county) Arkansas (State or foreign country)

16. (a) Informant Hospital Records
(b) Address Koch Hospital, Koch, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8, 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cem

18. (a) Signature of funeral director F. A. Green
(b) Address 2915 Franklin ave

19. (a) 4-11-46 (Date received local registrar) (b) E. M. Donaut M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 3 year 1946 hour 9 minute 45 A.M.

21. I hereby certify that I attended the deceased from 8-8- 1945 to 4-3- 1946 that I last saw him alive on 4-3- 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Generalized Tuberculosis	2 yrs. (?)
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] Ramendoit (M. D. or other)
Address Koch Hospital Date signed 4-3-46

707 (Licensed Embalmer's Statement on Reverse Side)

APR 18 1946

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 Melvin Edward Green, Registered Apprentice No. 383, working under my personal supervision.

Signed M. M. Green

Licensed Embalmer No. 1175

P. O. Address 357 Saledeen

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.

6. No. 2B
M—3-45
I X43680

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 826

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: Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 603 days (Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1403 N. 11th Street
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Nelson Winslow

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan (Month) 20 (Day) 1929 (Year)

8. AGE: Years 17 Months 2 Days If less than one day hr. min.

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

10. Usual occupation Porter

11. Industry or business

FATHER 12. Name Nathan Lee

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

MOTHER 14. Maiden name Edna Winslow

15. Birthplace Helena (City, town, or county) Arkansas (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Koch Hospital, Koch, Mo.

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 3 year 1946 hour 9 minute 45 A.M.

21. I hereby certify that I attended the deceased from 8-8 1945, to 4-3- 1946; that I last saw him alive on 4-3- 1946; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Pulmonary Tuberculosis	2 yrs
Tuberculosis of Bones (multiple)	(?)
Due to	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Samuel J. Kennedy (M. D. or other)

Address Koch Hosp. - Koch, Mo. Date signed 5/20/46

Kennedy

SUPPLEMENTARY

13353 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

14453