

No. 2  
-5-43  
-17-39  
X36671

FILED FEB 11 1948

Registration District No. 27

Primary Registration District No. 3066

Registrar's No. 304

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Kirkwood  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: U.S. Marine Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 27 days  
In this community unknown (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County 999  
(c) City or town O'Fallon, Ill.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 515 So. Vine St.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME BENJAMIN J. WINTERS (Windau)

3. (b) If veteran, name war unknown 3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased Dec. 20 1863  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
84 1 11 hr. \_\_\_\_\_ min.

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

10. Usual occupation Captain

11. Industry or business Str. Idlewild

12. Name John Winters

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

14. Maiden name Henrietta Reinkuehler

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

16. (a) Informant hospital records by patient

(b) Address U.S. Marine Hospital, Kirkwood, Mo

17. (a) BURIAL (b) Date thereof FEB. 4 48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director BEO. L. PLEITZCH

(b) Address 5966-68 EASTON AVE

19. (a) 2-2-48 (b) Beulah J. Haynes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 1st  
year 1948 hour 10:15 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from January 5  
1948 to February 1st, 1948;  
that I last saw him alive on Feb. 1st, 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis of lenticulostriate (rt) artery due to arteriosclerosis Duration 1 wk

Due to \_\_\_\_\_  
Due to 932

Other conditions Hypertensive cardiovascular disease  
(Include pregnancy within 3 months of death)

Major findings: Arteriosclerosis, general  
Of operations: Hemiplegia; Bronchopneumonia

Of autopsy \_\_\_\_\_  
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) NO

(b) Date of occurrence X

(c) Where did injury occur? X  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? X

(Specify type of place)  
While at work \_\_\_\_\_ (e) Means of injury XX

23. Signature David S. Citron (M. D. or other) 0

Address David S. Citron, S.A. Surg. U.S. Marine Hosp., Kirkwood, Mo Signed 2/1/48

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

Sr. Surgeon, Med. Off. in Charge

FEB 13 1948

---

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 Clement McQuay

Licensed Embalmer No. 3732

P. O. Address St. Louis

**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.**