

No. 2  
1/47  
17-39  
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED APR 30 1948  
Registration District No. 217

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
Primary Registration District No. 6076

State File No. 15078  
Registrar's No. 1029

1. PLACE OF DEATH:  
(a) County: St. Louis  
(b) City or town: Wellston Mo.  
(c) Name of hospital or institution: 6309 WAGNER PLACE 1  
(d) Length of stay: In hospital or institution: NONE  
In this community: 34 yrs.

2. USUAL RESIDENCE OF DECEASED:  
(a) State: MISSOURI (b) County: St. Louis 96  
(c) City or town: Wellston Mo. 0  
(d) Street No.: 6309 WAGNER PLACE 0  
(e) Citizen of foreign country? No. (Yes or No)

3. (a) PRINT FULL NAME: Addie Winston  
3. (b) If veteran, name war:   
3. (c) Social Security No.:

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month: April day: 19th year: 1948 hour: minute: M.  
21. I hereby certify that I attended the deceased from 17 Feb. 1947 to death 1947  
that I last saw him alive on 1947 and that death occurred on the date and hour stated above.

4. Sex: Female 5. Color or race: Negro  
6. (a) Single, widowed, married, divorced: Wid 7  
6. (b) Name of husband or wife:   
6. (c) Age of husband or wife if alive: 22 years  
7. Birth date of deceased: March 22, 1861

Immediate cause of death: Chs. myocarditis & nephritis

8. AGE: Years: 87 Months: 0 Days: 28 If less than one day: hr. min.

Due to: 131 N

9. Birthplace: Nashville Tenn. 1

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

10. Usual occupation: Nil  
11. Industry or business:  
12. Name: Unknown  
13. Birthplace: Unknown Unknown  
14. Maiden name: Unknown  
15. Birthplace: Unknown Unknown

PHYSICIAN  
Major findings: Of operations:  
Of autops:

16. (a) Informant: Virginia L. Mason  
(b) Address: 6309 Wagner Pl.  
17. (a) Burial: (b) Date of reef: 4-23-48  
(c) Place: burial or cremation: Green Wood Cem.  
18. (a) Signature of funeral director: Lee J. Smith  
(b) Address: 3615-17 Easton  
19. (a) 4-22-48 (b) Cecil Thompson

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?:  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?:  
23. Signatures: Address: Date signed:

**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.....

*H. E. Cooper*

Registered Apprentice No. *505*

working under my personal supervision.

Signed.....

*James Galt*

Licensed Embalmer No. *4441*

P. O. Address *2829 Washington*

**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.**

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Adde Wristen  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased March 2 (Month) 1944 (Day) 1944 (Year)

8. AGE: Years 87 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

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

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 1944 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

S-15078