

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 7 1949

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1003

State File No. 32339  
8261

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township)		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township)		d. STREET ADDRESS (If rural, give location)			
OR TOWN		ST. LOUIS		OR TOWN		ST. LOUIS			
d. FULL NAME OF HOSPITAL OR INSTITUTION				37204 IOWA AV				37204 IOWA AV	
3. NAME OF DECEASED (Type or Print)			a. (First)		b. (Middle)		d. (Last)		
ROBERT			L		WINCKEL		4. DATE OF DEATH (Month) (Day) (Year)		
5. SEX			6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		
M. M. W.			W.		M.		JAN. 3-1881		
9. AGE (In years last birthday)			if UNDER 1 YEAR		if UNDER 4 HRS.		11. BIRTHPLACE (State or foreign country)		
68 YRS			Months		Days		Mo. D		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
STATIONARY ENGINEER						Mo. D		U.S.A	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE			
CHARLES WINCKEL			LUCY HODDER			Mrs Helen F. Winckel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS				
YES			SPANISH		Helen F. Winckel 37204 Iowa				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)						48 hrs	
		ANTECEDENT CAUSES							
		*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.							
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
		DUE TO (b)							
		Probably due to arterio-sclerotic blood vessel rupture							
		DUE TO (c)							
		Malignant hypertension							
		II. OTHER SIGNIFICANT CONDITIONS							
		Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY)		21d. (STATE)			
				1021					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
				444 X					
22. I hereby certify that I attended the deceased from Aug. 1945, to Sept. 26, 1949, that I last saw the deceased alive on 7-24, 1949, and that death occurred at 6:30 A.M., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title)				23b. ADDRESS		23c. DATE SIGNED			
Elwin P. Schur				3258 Lafayette		9-26-49			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)			
BURIAL		SEPT 29-49		NATL CEMETERY		JEFFERSON BR. MO			
DATE REC'D BY LOCAL REG. SEP 26 1949		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					
		J. B. Losater		E. J. Schur 3258 Lafayette					

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

*Shuey*

**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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed

*Joseph Blodgett*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette Ave*

**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.