

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43090**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1002** Registrar's No. **10822**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY STO	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 5420 Plover Ave	
d. FULL NAME OF HOSPITAL OR INSTITUTION. 5420 Plover Ave		1	

3. NAME OF DECEASED a. (First) Esther		b. (Middle)		c. (Last) Winkelman		4. DATE OF DEATH (Month) (Day) (Year) Dec. 14, 1949	
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5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH March 23, 1897		9. AGE (In years last birthday) 52		IF UNDER 1 YEAR Months Days		IF UNDER 4 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
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13a. FATHER'S NAME Charles Sieckmann		13b. MOTHER'S MAIDEN NAME Elizabeth Gauding		14. NAME OF HUSBAND OR WIFE George Winkelman	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME George Winkelman ADDRESS 5420 Plover Ave	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Stomach				INTERVAL BETWEEN ONSET AND DEATH 6 Mo.	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause. (a) stating the underlying cause last.		DUE TO (b) Cancer of Breast		2 years	
				DUE TO (c)			
		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"/>	
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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) (STATE) STO MO	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 170X	
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22. I hereby certify that I attended the deceased from **12-9-**, 19**49**, to **12-14-**, 19**49**, that I last saw the deceased alive on **12-14-**, 19**49**, and that death occurred at **2:07 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE James T. Dean (Degree or title) MD		23b. ADDRESS 5536 Robin Drive		23c. DATE SIGNED 12-15-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-17-49		24c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
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DATE REC'D BY LOCAL DEC 16 1949		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Math. Hermann & Son, Inc. ADDRESS 2161 E. Fair Ave	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Horner W. Dritz

Licensed Embalmer No. 3882

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.