

No. 300
10-48

FILED AUG 25 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28878
Registrar's No. 7103

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis, 2139	
c. LENGTH OF STAY (in this place) 5 yrs 7 mo		d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary Hospital	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary Hospital		e. STREET ADDRESS 5600 Arsenal St., 0	

3. NAME OF DECEASED (Type or Print) Maggie Wynne			4. DATE OF DEATH (Month) (Day) (Year) 8 7 51		
5. SEX F	6. COLOR OF RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH Feb. 2-1864		9. AGE (In years last birthday) 87.
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) Kentucky		12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Leonard Stone		13b. MOTHER'S MAIDEN NAME Ange line Puckett		14. NAME OF HUSBAND OR WIFE Wm. Wynne	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME ADDRESS City Infirmary Records, 5600 Arsenal St.			
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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) Cerebral Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 2 days
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis			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 checked="" 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) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 332X		

22. I hereby certify that I attended the deceased from 7/6/1950, to 8/7, 1951, that I last saw the deceased alive on 8/7, 1951, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) George Esker, M.D.		23b. ADDRESS		23c. DATE SIGNED 8/7/51
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24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE 8-10-1951	24c. NAME OF CEMETERY OR CREMATORY Lake Charles Cem.	24d. LOCATION (City, town, or county) (State) St. Louis-County Mo	
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DATE REC'D BY LOCAL REG. AUG 9 1951	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS U. 2223 St. Louis 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 _____

Licensed Embalmer No. 1674

P. O. Address 2223 St. Louis 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.