

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31970

State File No.

FILED OCT 10 1951

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>8535</u>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u>)		c. LENGTH OF STAY (in this place) <u>17 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		<u>2079</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Christian Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>4910 Arlington Avenue 20</u>					
3. NAME OF DECEASED (Type or Print) <u>FRED</u>		a. (First)		b. (Middle)		c. (Last) <u>WINTER</u>			
4. DATE OF DEATH <u>Sept 25, 1951</u>				5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 30, 1882</u>		9. AGE (In years last birthday) <u>68</u>		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>25</u>			
11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Arnold Winter</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Moennig</u>			
14. NAME OF HUSBAND OR WIFE <u>Adelaide Sanders Winter</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>492-07-9947</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Adelaide Winter</u> ADDRESS <u>4910 Arlington</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Perinephritic abscess with paralytic ileus:</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>General arteriosclerosis:</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8-28-51</u> <u>to 9-25-51</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>9-15-51 as above:</u>				20. AUTOPSY? YES <input checked="" 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) _____ (STATE) _____		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? <u>570.1</u>							
22. I hereby certify that I attended the deceased from <u>8-28-51</u> , 19 <u>51</u> , to <u>9-25-51</u> 19 <u>51</u> , that I last saw the deceased alive on <u>8-24-51</u> , 19 <u>51</u> , and that death occurred at <u>6:20 a.</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>[Signature]</u>		23b. ADDRESS <u>HARRY A. KLEIN, M.D.</u> <u>5074 N. Union Blvd.</u> <u>St. Louis 15, Mo.</u>		23c. DATE SIGNED <u>9-26-51</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 28 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>SEP 26 1951</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>4748</u> ADDRESS <u>Bromschwig and Son W Florissant</u>					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING 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.....

.....
working under my personal supervision.

Student Embalmer No.

Student
Student Embalmer

Signed.....

John S. Penick
.....
Licensed Embalmer No. *4194*
P. O. Address.....

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.