

FILED APR 29 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14279

State File No. ....

BIRTH NO. ....

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. ....

3620

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Lutheran Hospital		e. STREET ADDRESS (If rural, give location) 16 3430 Gravois Ave. 21690	
3. NAME OF DECEASED (Type or Print) LUKE		4. DATE OF DEATH (Month) (Day) (Year) Apr. 20 1954	
a. (First)		b. (Middle) E.	
c. (Last) WINSTON			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sep. 10, 1881
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (Retired)		9b. KIND OF BUSINESS OR INDUSTRY Rice Stix Dry Goods Co.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and State or Foreign Country) Missouri	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Louis Winston		13b. MOTHER'S MAIDEN NAME Josephine Boyer	
13c. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE Clara Winston	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT'S SIGNATURE OR NAME Clara Winston	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS 3430 Gravois Ave.	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy ANTECEDENT CAUSES DUE TO (b) Arteriosclerosis with Hypertension 14y. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Aneurysm of abdominal aorta	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 5 1/2 mo.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19a. DATE 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.)	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 334 X	
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"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21f. HOW DID INJURY OCCUR	
22. I hereby certify that I attended the deceased from Oct. 20, 1953, to 4/20, 1954, that I last saw the deceased alive on 4/20, 1954, and that death occurred at 5:45 P.M., from the causes and on the date stated above.			
23a. SIGNATURE Albert N. Larson, M.D.		23b. ADDRESS 3606 Gravois	
23a. SIGNATURE		23c. DATE SIGNED 4/21/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal (MTR)		24b. DATE Apr. 23, 1954	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24d. LOCATION (City, town, or county) (State) Festus, Mo.	
DATE REC'D BY LOCAL REG. APR 21 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD	
DATE REC'D BY LOCAL REG.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.	

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

(Licensed Embalmer's Statement on Reverse Side)

1432

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.....  
Signature of Student Embalmer

Signed *John A. Harrison*

Licensed Embalmer No. 4537

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.