THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

3191

STATE FILE NUMBER

FILED JAN 25 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 53

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS Mo — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 01 2918 a NEBRASKA — Length of stay in 1b: 24

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: ST. LOUIS — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2918 a NEBRASKA — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First CHARLES Middle J. Last WINTERS

4. DATE OF DEATH: Month JAN. Day 2 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 15 1871

9. AGE (In years last birthday): 85

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): MISSOURI

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDWARD WINTER

14. MOTHER'S MAIDEN NAME: UNKNOWN

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.: 490-14-9321

17. INFORMANT: EDNA STAPINSKI — Address: 2918 a NEBRASKA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial infarction

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Myocarditis due to arteriosclerosis

DUE TO (c): Emphysema; Ch Bronchitis

INTERVAL BETWEEN ONSET AND DEATH: 1 wk

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

420.0

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1951, to 12-27-1956 and last saw her/him alive on 12-27-56

Death occurred at 6:50 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Ralph Berg MD (Degree or title)

22b. ADDRESS: 3203 S Grand

22c. DATE SIGNED: 1/3/57

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: JAN. 5 1957

23c. NAME OF CEMETERY OR CREMATORY: New Picker Cem.

23d. LOCATION (City, town, or county) (State): ST. LOUIS Mo

24. FUNERAL DIRECTOR: Thomas Butler — ADDRESS: 2906 Gravois

25. DATE RECD. BY LOCAL REG.: JAN 4 1957

26. REGISTRAR'S SIGNATURE: J Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in filling in the symptoms which produced death. Do not use abbreviations or symbols. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 434

P. O. Address 2906

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.