

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38366

FILED NOV 15 1957

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10550

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> <u>2084</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>De Paul Hosp.</u>		Length of stay in lb <u>29 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>341 Christian</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julius</u> Middle <u>F.</u> Last <u>Wind</u>			4. DATE OF DEATH Month <u>11</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-28-1914</u>	9. AGE (In years last birthday) <u>43</u>	10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>X-ray Coder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ruck X-Ray Co</u>	11. BIRTHPLACE (City and state or country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>Austria</u>	
13a. FATHER'S NAME <u>Julius Wind</u>		13b. MOTHER'S MAIDEN NAME <u>Rosa Wind</u>		14. NAME OF HUSBAND OR WIFE <u>Never married</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>494-07-6032</u>	17. INFORMANT Address <u>Rose Oswald - 341 Christian</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-sclerosis</u>					?	
DUE TO (c) <u>Diabetis</u>					<u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>260x 1</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.						
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>10/6/57</u> to <u>11/5/57</u> and last saw <sup>her</sup> him alive on <u>11/4/57</u> Death occurred at <u>12:45 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Robert J. Sansone M.D.</u>			22b. ADDRESS <u>8321 N. B. Way</u>		22c. DATE SIGNED <u>11/6/57</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Cremial</u>	23b. DATE <u>11-8-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or country) (State) <u>St. Louis Mo</u>		
24. FUNERAL DIRECTOR <u>Edw. Koch &amp; Son - 3516 N. 14th</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>NOV 7 '57</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>m &amp; B</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Robert M. Murray* .....  
Licensed Embalmer No. *3749* .....  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.