

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034506

FILED VS OCT 5 1959
FILED IN THE OFFICE OF THE REGISTRAR

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 8781**

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in 1b 93 days	c. CITY OR TOWN Evansville
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 110 Washington Ave.

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	OLIVIA	M.	WINIGER	SEPTEMBER 22, 1959			

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/30/1899	9. AGE (last birthday) 59	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary	10b. KIND OF BUSINESS OR INDUSTRY Private Office	11. BIRTHPLACE (City and state or country) Evansville, Ind.	12. CITIZEN OF WHAT COUNTRY U.S.
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13a. FATHER'S NAME Edmund Winiger	13b. MOTHER'S MAIDEN NAME Dorothy Salzman	14. NAME OF HUSBAND OR WIFE None
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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. Unknown	17. INFORMANT A.A. Winiger, McCulchanville, Ind.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary Embolism with infarction	4 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Malignant Astrocytoma	7 months
	DUE TO (c) 193-9	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from **6/19/59** to **9/22/59** and last saw her **live** on **9/22/59**
 Death occurred at **3:25 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. D. Vermillion, M.D.</i>	(Degree or title) M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 9/23/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-25-59	23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery	23d. LOCATION (City, town, or county) (State) Evansville, Ind.
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24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.	ADDRESS	25. DATE REC'D BY LOCAL REG. SEP 23 1959	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF MISSOURI

DEPARTMENT OF HEALTH

STATE BOARD OF HEALTH

CERTIFICATE OF EMBALMING

THIS IS TO CERTIFY THAT THE BODY OF _____

DECEASED AT _____

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 Lawrence O. Berling

Licensed Embalmer No. 4979

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.

STATE BOARD OF HEALTH

MISSOURI DEPARTMENT OF HEALTH