

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS FEB 1 1960

-60-004250

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 179** STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b | | c. CITY OR TOWN Jefferson Bks. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 1033 Kilner St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First William Middle Carl Last Winheim | | | 4. DATE OF DEATH Month January Day 5 , Year 1960 | | | | | |
| 5. SEX Male | 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 Jan. 5, 1960 | 9. AGE (last birthday) IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours 7 Min. _____ | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY U S A | |
| 13a. FATHER'S NAME William Winheim | | | 13b. MOTHER'S MAIDEN NAME Jo Ann Fisk | | | 14. NAME OF HUSBAND OR WIFE ----- | | |
| 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. None | | 17. INFORMANT Address Wm. C. Winheim 1033 Kilner St. Louis 25, Mo. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema due to anoxia | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO (b) Delayed respiration | | | | | | | | |
| DUE TO (c) premature onset of labor 762.5 | | | | | | | | |
| 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 type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. | | Month, Day, Year | | | | | | |
| 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 |
| 21. I attended the deceased from birth to _____ and last saw her/him alive on _____ Death occurred 10.30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>Wm. Eades M.D.</i> | | | | 22b. ADDRESS 7602 So. Broadway | | | 22c. DATE SIGNED 1/6/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE Jan. 7, 1960 | 23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery | | 23d. LOCATION (City, town, or county) (State) 2000 Lemay Ferry Rd. Lemay, Mo. | | | |
| 24. FUNERAL DIRECTOR ADDRESS C. Hoffmeister Mortuaries 6464 Chippewa St. | | | | 25. DATE RECD. BY LOCAL REG. JAN 7 1960 | | 26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____
Licensed Embalmer No. _____
P.O. Address _____

Not Embalmed

J. [Signature]

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.