MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JUL 7 1960

60-025327
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500-0.500 Registrar's No. 1924

1. PLACE OF DEATH
a. COUNTY: ST LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Florissant — Length of stay in 1b: 9 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis Co. Hospital — Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: ST LOUIS
c. CITY OR TOWN: Florissant, Mo., — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): Box 406 Rt. 3 Florissant — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Robert Middle: Last: Windle
4. DATE OF DEATH: Month 6 Day 23 Year 60

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Aug. 29 1893
9. AGE (last birthday): 66 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Furnace Man
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): Chester, Illinois
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Robert E. Wind;e
13b. MOTHER'S MAIDEN NAME: Maggie Faverty
14. NAME OF HUSBAND OR WIFE: Lillie Windle

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.: Unknown
17. INFORMANT: Mrs. L. Windle Florissant, Mo., Address

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): Epidermoid Carcinoma of Right Lung
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

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. ☐ Yes ☐ No ☐ Unknown

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.)
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 June 14, 1960, to June 23, 1960 and last saw ~~her~~ him alive on June 23, 1960
Death occurred at 10⁰⁰ A.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Morris Goda (Degree or title) M.D.
22b. ADDRESS: 601 S. Brentwood Bl. Clayton, Mo.
22c. DATE SIGNED:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: June 27/1960
23c. NAME OF CEMETERY OR CREMATORY: Memorial Pk. Cem.
23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR ADDRESS: Leidner Undertaking Co. 2223 St. Louis Av
25. DATE RECD. BY LOCAL REG.: 6-24-60
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 Albert Mayfield

Licensed Embalmer No. 1307

P. O. Address St Louis

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