

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004761

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 193 STATE FILE NUMBER

**FILED JAN 19 1962**

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 <b>St. Louis</b>			c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Infirmery</b>			d. STREET ADDRESS <b>2517 Slatery St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Alma</b> Middle <b>Winston</b> Last			4. DATE OF DEATH Month <b>Jan.</b> Day <b>1</b> Year <b>1962</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-22-1918</b>	9. AGE (last birthday) <b>43</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Thomasville, Ark.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Arthur Waller</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Fair</b>		14. NAME OF HUSBAND OR WIFE <b>Lloyd Winston</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lloyd Winston 2517 Slatery St.</b>	

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) <b>Pulmonary Embolism</b>			
DUE TO (b) <b>Thrombophlebitis left leg</b>			
DUE TO (c) <b>463X</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Abscess rectum hemorrhoids</b>			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

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 <b>St. Louis</b>	COUNTY <b>St. Louis</b>	STATE
--	--	--	----------------------------	-------

21. I attended the deceased from July 1961 to Jan 1962 and last saw her/him alive on Dec 30, 1961  
Death occurred at 7 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. McNamee</i>	(Degree or title)	22b. ADDRESS <b>4901 Keston Schouis</b>	22c. DATE SIGNED <b>Jan 3, 1962</b>
-------------------------------------	-------------------	--	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-8-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis County, Mo.</b>
---	----------------------------	---	---

24. FUNERAL DIRECTOR <b>G. Wade G. Anberry</b>	ADDRESS <b>4202 Finney Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 5 1962</b>	26. REGISTRAR'S SIGNATURE <i>Neal Smith, M.D.</i>
---	------------------------------------	---	--

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DATE AMENDED  
 ITEM NO. SHOULD READ  
 BY AFFIDAVIT OF DOCUMENT 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 Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.

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.