

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026539

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6275 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED

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USE BLACK INK OR TYPEWRITER RIBBON
 YOUNG

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>4236 VERTRUDE</u>		If outside, give location		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JONES WINGERTER</u>						4. DATE OF DEATH Month Day Year <u>JUNE 12, 1963</u>					
5. SEX <u>MALG</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 18 83</u>		9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HAULING</u>		11. BIRTHPLACE (City and state or country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>FRANK WINGERTER</u>				13b. MOTHER'S MAIDEN NAME <u>CARDELIA FARRAR</u>				14. NAME OF HUSBAND OR WIFE <u>LOTTIE (dec)</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.		17. INFORMANT <u>BIRDIE GUSCIC</u>		Address <u>4236 VERTRUDE</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>Septicemia</u> DUE TO (b) <u>Post operative wound infection</u> DUE TO (c) <u>610X</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Benign prostatic hypertrophy, diabetes mellitus</u>								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		COUNTY STATE	
21. I attended the deceased from <u>5/25/63</u> to <u>6/12/63</u> and last saw her/him alive on <u>6/12/63</u> Death occurred at <u>8 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>James B. Young M.D.</u>						22b. ADDRESS <u>1515 LAFAYETTE AVE</u>			22c. DATE SIGNED <u>6/12/63</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>JUNE 15, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New ST MARCUS</u>				23d. LOCATION (City, town, or county) <u>ST LOUIS</u>		(State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Thomas Kuteis 2906 Gravois</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>JUN 13 1963</u>		26. REGISTRAR'S SIGNATURE <u>Roan Smith M.D.</u>			

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 _____

Licensed Embalmer No. 3403

P. O. Address 2906 gloom

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.