

FILED NOV 24 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39934

State File No. 9744

Registrar's No. 9744

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 72 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2165	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3421 Wyoming st.			STREET ADDRESS (If rural, give location) 16 3421 Wyoming St.		
3. NAME OF DECEASED a. (First) William		b. (Middle) George		c. (Last) Winter	
4. DATE OF DEATH (Type or Print) Nov. 3, 1951		5. SEX Male D		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Oct. 6, 1879		9. AGE (In years last birthday) 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman		10b. KIND OF BUSINESS OR INDUSTRY Electrical Mfg.		11. BIRTHPLACE (State or foreign country) St. Louis, Mo. D	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Joseph Winter		13b. MOTHER'S MAIDEN NAME Sarah Ann Stone	
14. NAME OF HUSBAND OR WIFE Clara Rasback Winter		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. _____	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Clara R. Winter, 3421 Wyoming St.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL VASCULAR HEMORRHAGE ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ARTERIO SCLEROSIS DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH 1 HOUR. UNK.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR		22. I hereby certify that I attended the deceased from DEC 19, 1947, to NOV 3, 1951, that I last saw the deceased alive on 10-30-1951, and that death occurred at 2:30 A.M., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Henry T. Cooper M.D.		23b. ADDRESS 518 Olive St.		23c. DATE SIGNED 3 NOV 1951	
24a. BURIAL, CREMATION, REMOVAL Removal		24b. DATE Nov. 5, 1951		24c. NAME OF CEMETERY OR CREMATORY New St. Marcus	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Beiderwieden F.H. Inc., 1936 St. Louis Av.		DATE REC'D BY LOCAL REG. NOV 5 1951	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Hy. T. Cooper,
Paul Brown Bldg.
Sat. 1-4 pm

1115

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 _____

working under my personal supervision.

Student
Student Embalmer

Signed Sebit J. Krissin

Licensed Embalmer No. 3497

P. O. Address 1936 St. Louis

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 this body is not embalmed, fact should be so stated above.