

REC'D MAR 13 1939

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

4436  
Do not use this space.

**1. PLACE OF DEATH**

(a) County.....  
(b) Township.....  
(c) City St. Louis

Registration District No. 791  
Primary Registration District No. 1003  
(d) Street No. City Hospital No. 1

Registered No. 1129

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

D.14584 236 Vinko Vincent Kuster

**2. PRINT FULL NAME**

(a) Residence, No. 2207 Chestnut St. 21  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Katherine Kuster

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) About 1882

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
53 Unknown

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc. nil  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austria 7

FATHER 13. NAME Amber Kuster 7  
Austria

MOTHER 15. MAIDEN NAME Unknown 9  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Hosp Info M. Kent  
(ADDRESS) City Hospital

18. BURIAL, CREMATION, OR REMOVAL New S.S. Peter & Paul DATE Feb. 6, 1939

19. FUNERAL DIRECTOR (NAME) Wm. C. Moydell  
(ADDRESS) 1926 Allen Ave.

20. FILED FEB 4 1939 J. D. Buehler Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/3/39 19

22. I HEREBY CERTIFY That I attended deceased from 1/6/39 to 2/3/39 19

I last saw him alive on 2/3/39 19. Death is said to have occurred on the date stated above, at 9.21 a m.  
The principal cause of death and related causes of importance were as follows:

Chronic myocarditis

Date of onset

Other contributory causes of importance:

generalized arteriosclerosis

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury..... 19

Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify.....

(Signed) C. D. Buehler, M. D.

(Address) City Hospital No. 1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Benj. C. Duncan

Licensee Embalmer No. 2272

P. O. Address 172-6 Allen

**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, above space should be left blank.**