

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

No. 2  
- 42  
17-59  
X32873

REC JUN 10 1943

Registration District No. 3.10

Primary Registration District No. 30.58

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town St. Charles

(c) Name of hospital or institution: St. Joseph Hospital  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution Three Weeks  
(Specify whether In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 39

(c) City or town Springfield  
(If outside city or town limits, write "RURAL")

(d) Street No. 1032 St. Louis  
(If rural, give location)

(e) Citizen of foreign country? No (Yes of No) 6  
If yes, name country 1

3. (a) PRINT FULL NAME Laurina Edna Karstein

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Benjamin S. Karstein

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased April 17 1969  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

74 0 29 hr. min.

9. Birthplace Louisville Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown - Garrison

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ethel Eric Intosh

(b) Address Old Monroe, Mo.

17. (a) Removal (b) Date thereof May 17 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield Mo.

18. (a) Signature of funeral director H. C. Dellmeyer & Sons

(b) Address 301 N. Second, St. Charles, Mo.

19. (a) 5/18/43 (b) Ernest G. Paule  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16  
year 1943 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from May 2  
1943 to May 16 1943  
that I last saw her alive on May 16 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Edema - 24 hr.  
Pulmonary congestion - 3 day

Due to fracture right hip - severity

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury ✓

23. Signature Vincent A. Johnson (M. D. or other) MD

Address St. Charles Mo Date signed 5/17/43

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

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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 John E Dallmeyer  
Licensed Embalmer No. 2951  
P. O. Address St Charles Mo.

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 88

1. PLACE OF DEATH:

- (a) County St Charles
- (b) City or town St Charles  
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Laurina Edna Kaaden

- 3. (b) If veteran, name war \_\_\_\_\_
- 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 17 1868  
(Month) (Day) (Year)

8. AGE: Years 74 Months 0 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_
- (c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")
- (d) Street No. \_\_\_\_\_  
(If rural, give location)
- (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary edema  
Pulmonary congestion  
Due to Fracture right hip  
Due to senility

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident O.T.G.

(b) Date of occurrence April 26 - 1943

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? in home

While at work? no (Specify type of place) (e) Means of injury Fall

23. Signature Vernette Schuster (M. D. or other) \_\_\_\_\_

Address St Charles, Mo Date signed 6/18/43

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

SUPPLEMENTARY

5-18877