V. S. No. 2
100M—5-43
Rev. 5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 1 1944

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32480

Primary Registration District No. 1003

Registrar's No. 8958

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Bethesda General Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days (Specify whether years, months or days)

In this community 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1009 Wachtel-Lemay NR
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Carol Ann Kester-mont

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 1

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased November (Month) 17 (Day) 1942 (Year)

8. AGE: Years 1 Months 11 Days 4 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

10. Usual occupation

11. Industry or business Mon Santo Chemical Co.

FATHER
12. Name Rolla Kester-mont
13. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Theresa Schmitt
15. Birthplace St. Geniviere (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Rolla Kester-mont
(b) Address 1009 Wachtel Lemay.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director Fendler Und. Co.
(b) Address 7420 Michigan Avenue

19. (a) OCT 23 1944 (Date received local registrar) (b) J. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 21 year 1944 hour 3 minute 05 P M.

21. I hereby certify that I attended the deceased from Birth 1942 to 10/21 1944 that I last saw he alive on 10-21 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Brights & Pyealitis

Due to

Due to

Other conditions Spina bifida at Birth
(Include pregnancy within 3 months of death)

Major findings:
Of operation Amputation Lower limbs

Of autopsy no

Duration

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)

(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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature J M Barker M.D. (M. D. or other)

Address 4504 S Jefferson Date signed 10/24 44

(Licensed Embalmer's Statement on Reverse Side)

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. emb. cert filed separately

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.