S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 16 1945

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 20653

Registration District No. 16 Primary Registration District No. 5596 Registrar's No. 34

1. PLACE OF DEATH:
(a) County De-Soto, Mo.
(b) City or town Jefferson County
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Route 1 - Box 41A
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 50
(c) City or town De Soto, MO 0
(If outside city or town limits, write "RURAL")
(d) Street No. Route 1, Box 41A
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Katie Kyburz
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Henry
6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased March (Month) 14 (Day) 1870 (Year)

8. AGE: Years 74 Months 2 Days 6 If less than one day hr. min.

9. Birthplace Sulphur Springs (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Home
11. Industry or business
FATHER
12. Name Bernard Engel
13. Birthplace (City, town, or county) Germany (State or foreign country) 11
MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown (State or foreign country) 9
16. (a) Informant Henry Kyburz
(b) Address Rt1-Box 41A DeSoto, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation St. Matthews Cemetery
18. (a) Signature of funeral director Wacker-Helderle
(b) Address 3634 Gravois Avenue.
19. (a) 5-23-45 (Date received local registrar) (b) Fern Spencer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20 year 1945 hour 10 minute A M.
21. I hereby certify that I attended the deceased from Mar 1, 1945, to May 20, 1945 that I last saw her alive on May 16, 1945 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Hypostatic pneumonia | 5 da |
| Due to Cerebral hemorrhage | 2 mo |
| Due to Hypertension (essential) | unknown |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy 83 a

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
23. Signature J. P. Ingels (M.D. or other) DO
Address De Soto, Mo. Date signed 5/21/45

387

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 6-14-45

JUN 20 1945

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 Robert C Wheeler

Licensed Embalmer No. 2128

P. O. Address St Louis 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.**