

S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11829

State File No. \_\_\_\_\_

Registration District No. 317

Primary Registration District No. 306

Registrar's No. 611

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Mary Hosp,  
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 96

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

(d) Street No. 231 Arlee  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Barbara Kastner

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 Karl Kastner

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Aug. 20 1901  
(Month) (Day) (Year)

8. AGE:

| Years     | Months   | Days      | If less than one day |
|-----------|----------|-----------|----------------------|
| <u>44</u> | <u>6</u> | <u>23</u> | _____ hr. _____ min. |

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

10. Usual occupation House Wife

11. Industry or business At Home

MOTHER FATHER {

12. Name Anthony Hols

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

14. Maiden name Unknown

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

16. (a) Informant Karl Kastner

(b) Address 231 Arlee

17. (a) \_\_\_\_\_ (b) Date thereof 3/18/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olive Cem

18. (a) Signature of funeral director Fendler Und Co

(b) Address 7420 Michigan ave

19. (a) 3-18-47 (b) Ruth Allen MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 15  
year 47 hour 1:00 minute 14 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
that I last saw her aw alive on 3/15/47 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Uremia

Due to Uteral Obstruction 4 1/2

Due to Arteriosclerosis of Brain & Coronary Arteries

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

Duration 36 hrs  
48'

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy As above

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? \_\_\_\_\_

23. Signature Paul F. Hols  
Address 634 N. Grand Ave.  
Date signed 3/19/47

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

16  
3

*John 12 2000 -*

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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 *Oliver E. Fenwick*.....

Licensed Embalmer No. *4148*.....

P. O. Address *Long*.....

**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.**