

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

34348
9316

FILED NOV 6 1948

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Deaconess Hospital
(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)

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. 6435 Devonshire
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME: Infant James Kippenberger

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

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

7. Birth date of deceased Oct. 25 1948
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 1 hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Jerome Kippenberger

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

14. Maiden name Marie Winterer

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

16. (a) Informant Jerome Kippenberger

(b) Address 6435 Devonshire

17. (a) Burial (b) Date thereof 10-27-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Resurrection Cem.

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

(b) Address 4228 S. Kingshighway Bl.

19. (a) OCT 28 1948 (b) J. B. Lasater
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 26
year 1948 hour 11:45 minute A. M.

21. I hereby certify that I attended the deceased from Oct 25-48
to Oct 26 48
and that death occurred on the date and hour stated above.

that I last saw him alive on Oct 26 1948
and that death occurred on the date and hour stated above.

Immediate cause of death atrophic
ulcerosis (congestive)

Duration life

Due to _____

Due to _____

Other conditions 161
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy alone

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. Costello (M. D. or other)

Address 4932 Maryland Date signed 10/27/48

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

MOTHER FATHER

*Pro-Choice Party
Dr. Joe Costello MD 1100
495-1100 10-1*

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..... *Edwin M. Bennett*

Licensed Embalmer No..... *3024*

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.