

FILED JAN 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2874
331
Registrar's No.

318

1009

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo</i> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give town) <i>ST LOUIS</i>		c. LENGTH OF STAY (in this place) <i>11 days 11 hrs</i>		c. CITY (If outside corporate limits, write RURAL and give township) <i>ST LOUIS</i>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>FAITH HOSPITAL</i>				d. STREET ADDRESS (If rural, give location) <i>4517 MAFFIT AVE</i>			
3. NAME OF DECEASED (Type or Print) a. (First) <i>NELLIE</i>		b. (Middle) <i>LAURA</i>		c. (Last) <i>KAUFHOLTZ</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>1 10 1949</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>DIVORCED</i>		8. DATE OF BIRTH <i>10-29-1882</i>	
9. AGE (to years last birthday) <i>66</i>		IF UNDER 1 YEAR Months <i>2</i> Days <i>11</i>		IF UNDER 2 WKS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>MONTGOMERY CITY Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13a. FATHER'S NAME <i>CEYLON ZUMWALT</i>		13b. MOTHER'S MAIDEN NAME <i>GEORGIA ANN WALD</i>		14. NAME OF HUSBAND OR WIFE <i>WILLIAM KAUFHOLTZ</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>NONE</i>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>George E. Kaufholz 4517 Maffit Ave</i>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Multiple Myeloma</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Brain tumor</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Pneumonia, Secondary Chronic passive congestion of the heart</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i> <i>55 14 18</i> <i>5 days 5 days</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/23</i> , 19 <i>48</i> , to <i>1-10</i> , 19 <i>49</i> , that I last saw the deceased alive on <i>1-10</i> , 19 <i>49</i> , and that death occurred at <i>9:09</i> m., from the causes and on the date stated above.							
23a. SIGNATURE <i>J. B. Lasater</i>		(Degree or title) <i>M.D.</i>		23b. ADDRESS <i>7801 No Taylor</i>		23c. DATE SIGNED <i>1-10-49</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24b. DATE <i>1-13-49</i>		24c. NAME OF CEMETERY OR CREMATORY <i>OAK GROVE</i>		24d. LOCATION (City, town, or county) (State) <i>WELLSTON Mo</i>	
DATE REC'D BY LOCAL <i>JAN 12 1949</i>		REGISTRAR'S SIGNATURE <i>J. B. Lasater</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Hindberg Funeral Home</i>		ADDRESS <i>Webster Groves Mo</i>	

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Albert G. Hopper

Signed _____
Student Embalmer

Licensed Embalmer No. 2971

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.