

FILED NOV 10 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35313

State File No. 9413

318

1003

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 <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>Richmond Heights</u>		d. STREET ADDRESS (If rural, give location) <u>W-6375 Clayton Rd.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Anthonys Hospital</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 31 1949</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Hazel</u>		b. (Middle) <u>H.</u>		c. (Last) <u>Kjar</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>June 28 1912</u>	
9. AGE (In years last birthday) <u>37</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Portland Oregon</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>Capt Herman Freese</u>		13b. MOTHER'S MAIDEN NAME <u>Hazel Buchanan</u>		14. NAME OF HUSBAND OR WIFE <u>Oliver Cl Kjar</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Oliver J. Kjar, 6375 Clayton Rd.</u>			
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) <u>Blood Aut-Polem nephritis</u> ANTECEDENT CAUSES <u>Bulbo Encephalic with Resperatory Paralysis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>7 days?</u>	
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) <u>310</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>0800</u>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:15</u> A.M., from the causes and on the date stated above.							
23a. SIGNATURE <u>M. M. Cook M.D.</u> (Degree or title)				23b. ADDRESS <u>St. Anthonys Hosp.</u>		23c. DATE SIGNED <u>10-31-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>11-3-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>NOV 1 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Drehmann-Herral, 1905 Union Blvd.</u> ADDRESS _____			

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.

Student .....  
Student Embalmer

Signed Warren P. Carver.....

Licensed Embalmer No. 3534.....

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.