

FILED JUN 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18338

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4087

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.		b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Carondelet		4190	
c. LENGTH OF STAY (In this place) 93 days		d. STREET ADDRESS 8813 Ramona		/	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes					

3. NAME OF DECEASED a. (First) Gladys		b. (Middle) Jane		c. (Last) Kesselring		4. DATE OF DEATH (Month) (Day) (Year) May 5 '50	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH Sept 25, 1911	
9. AGE (In years last birthday) 38		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Earl Eaton		13b. MOTHER'S MAIDEN NAME Edna Redmond		14. NAME OF HUSBAND OR WIFE Charles Kesselring	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charles Kesselring 8813 Ramona			
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive failure				INTERVAL BETWEEN ONSET AND DEATH 5 years	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Rheumatic heart disease					
		DUE TO (c) Cardiac cirrhosis					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

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)		21f. HOW DID INJURY OCCUR? 416X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					

22. I hereby certify that I attended the deceased from Feb 2, 1950, to May 5, 1950, that I last saw the deceased alive on May 5, 1950, and that death occurred at 12:50 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) FR Ruddy M.D.		23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 5/5/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 18 1950		24c. NAME OF CEMETERY OR CREMATORY Laurel Hills	
24d. LOCATION (City, town, or county) (State) Welston Mo.		DATE REC'D BY LOCAL REG. MAY 5 1950		REGISTRAR'S SIGNATURE J. B. Laster	
25. FUNERAL DIRECTOR'S SIGNATURE Street-Correll		ADDRESS 4600 Nat'l Bridge			

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

me

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 _____

working under my personal supervision.

Student Embalmer No.

Signed *Bend Hoffman*

Signed
Student Embalmer

Licensed Embalmer No. *4366*

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.