

FILED MAR 8 1951

STANDARD CERTIFICATE OF DEATH

State File No. 6942

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3066 Registrar's No. 574

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St Louis	
b. CITY (If outside corporate limits, write RURAL and give township) Kirkwood		c. CITY (If outside corporate limits, write RURAL and give township) 71 Kirkwood	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 305 Frieda Ave	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 305 Frieda Ave			

3. NAME OF DECEASED (Type or Print)	a. (First) Elizabeth	b. (Middle)	c. (Last) Karsnick	4. DATE OF DEATH (Month) March (Day) 2 (Year) 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct 23 1883	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 4 Days 9	IF OVER 24 HRS. Hours 9 Min.
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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) Arkansas	12. CITIZEN OF WHAT COUNTRY? Amer.
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13a. FATHER'S NAME Peter Bopp	13b. MOTHER'S MAIDEN NAME Anna Wilhelm	14. NAME OF HUSBAND OR WIFE Ernst Karsnick
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, if unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Raymond O Douglas ADDRESS Kirkwood 22 Mo
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Oesophagus		
	ANTECEDENT CAUSES 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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **2-27**, 1951, to **3-1**, 1951, that I last saw the deceased alive on **3-1**, 1951, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Rosal C. McLean M.D. (Degree or title)	23b. ADDRESS Kirkwood Mo	23c. DATE SIGNED 3-3-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-5-51	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	24d. LOCATION (City, town, or county) (State) St Louis County Mo.
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DATE REC'D BY LOCAL REG. 3-3-51	REGISTRAR'S SIGNATURE Norbert R Donke M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Meyer-Pfizinger ADDRESS Kirkwood 22 Mo.
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RWR (Licensed Embalmer's Statement on Reverse Side)

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

Dr McLean

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.....
Student Embalmer

Signed *William H. Kitzinger*

Licensed Embalmer No. *4316*

P. O. Address *Kirkwood, 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.