

FILED APR 27 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003 State File No. 13891
318 PRIMARY REG. DIST. NO. 3484
REG. DIST. NO. 1003 Registrar's No.

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS 217.9	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3917 ^A CASTLEMAN		STREET ADDRESS (If rural, give location) 3917 ^A CASTLEMAN AV	
3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) CASPER c. (Last) KETTLE		4. DATE OF DEATH (Month) (Day) (Year) APRIL-11-51	
5. SEX M.	6. COLOR OR RACE W	7. MARRIED—NEVER MARRIED, WIDOWED, DIVORCED (Specify) D 2	8. DATE OF BIRTH OCT 20-1875
9. AGE (In years last birthday) 75 1/2	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE WORKER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME unknown KETTLE	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE	
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 Mrs. J. BLAKE-4986 NAGLE RD		ADDRESS	
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) Carcinoma of Prostate 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. Acute Retention	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 177X		22. I hereby certify that I attended the deceased from March 10, 1951, to April 11, 1951, that I last saw the deceased alive on April 11, 1951 and that death occurred at 10A m., from the causes and on the date stated above.	
23a. SIGNATURE H. J. Moore MD		23b. ADDRESS 917-8018	
23c. DATE SIGNED 4-13-51		24a. BURLIAL, CREMATION, REMOVAL, etc. BURIAL	
24b. DATE APRIL 14 51		24c. NAME OF CEMETERY OR CREMATORY NEW PICKERS Cem.	
24d. LOCATION (City, town, or county) (State) ST. LOUIS MO		DATE REC'D BY LOCAL REG. APR 14 1951	
REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schuur	
ADDRESS		3125 Lafayette	

Statement of Embalmer

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 *Jan B. Hollman*.....

Signed.....
Student Embalmer

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette*

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.