

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40251**

XC 15 556 112
Reg. 97751
FILED NOV 24 1951
BIRTH NO.

REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **3677**

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

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN JEFF. BRKS. MO.)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (in this place) 17 Days		d. STREET ADDRESS (If rural, give location) 4330 LAFAYETTE AVE.	
d. FULL NAME OF HOSPITAL OR INSTITUTION VET. ADM. HOSP.			
3. NAME OF DECEASED (Type or Print) a. (First) BEN		b. (Middle) KAUFFMAN	
c. (Last) KAUFFMAN		4. DATE OF DEATH (Month) (Day) (Year) 11/12/51	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3/19/04
9. AGE (In years last birthday) 50 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Max Kauffman	
13b. MOTHER'S MAIDEN NAME Anna Carafoil		14. NAME OF HUSBAND OR WIFE Molly Kauffman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World I Unknown	
17. INFORMANT'S SIGNATURE OR NAME V. A. HOSPITAL RECORDS		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS	
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"/>		4301	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) NONE		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) - VA - 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 10/26 1951 , to 11/12 1951 , that I last saw the deceased at 4:00 p.m. , and that death occurred at 4:00 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Robert A. Doisy M.D.		23b. ADDRESS V. A. HOSP. JEFF. BRKS. MO.	
23c. DATE SIGNED 11/12/51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/14/51	
24c. NAME OF CEMETERY OR CREMATORY B'nai amoona		24d. LOCATION (City, town, or county) (State) University City Mo.	
DATE REC'D BY LOCAL REG. 11-13-51		REGISTRAR'S SIGNATURE Robert P. Donker	
25. FUNERAL DIRECTOR'S SIGNATURE Berger		ADDRESS emorial 4715 McPherson	

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 *James A. Ludwig* _____

Licensed Embalmer No. *4229* _____

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.