

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43109
1003 State File No. 11301

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</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) <u>4</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		2749	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>WASHINGTON UNIVERSITY CLINIC</u>				f. STREET ADDRESS (If rural, give location) <u>1939 BLENDEN</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u>		b. (Middle) <u>ANN</u>		c. (Last) <u>KULICK</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12 19 51</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>		8. DATE OF BIRTH <u>Nov. 15, 1938</u>	
9. AGE (In years last birthday) <u>13</u>		IF UNDER 1 YEAR Months <u>1</u>		IF UNDER 4 HRS. Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>PAUL J. KULICK</u>		13b. MOTHER'S MAIDEN NAME <u>HAZEL REINSCHEIDT</u>		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 ADDRESS <u>Mrs. Paul J. Kulick, 1939 Blenden St.</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Insufficiency</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Glomerulonephritis</u> 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>3 months</u> <u>9 yrs</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) <u>NO</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>NONE</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>592 X</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>10:10 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Wm. H. Klingberg, MD.</u>				23b. ADDRESS <u>500 S. Kingshighway</u>		23c. DATE SIGNED <u>12-19-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12/22/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, County, Mo.</u>	
DATE REC'D BY LOCAL HEALTH DEPT. <u>DEC 20 1951</u>		REGISTRAR'S SIGNATURE <u>Earl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Chulick Und. Co. 1722 S. Jefferson</u>			

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

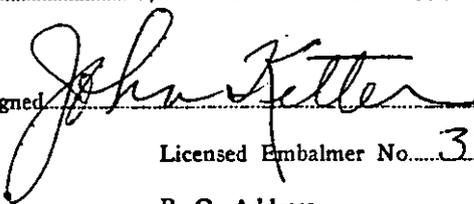
STATEMENT BY LICENSED EMBALMER

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  _____

Licensed Embalmer No. 3880

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.