

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 29707  
 Registrar's No. 7443

FILED AUG 23 1952

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>7443</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b>				b. COUNTY <b>2069</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis 5</b>			c. LENGTH OF STAY (in this place) <b>53 yrs.</b>			c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis 0</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Anns Widows Home</b>				d. STREET ADDRESS (If rural, give location) <b>6 5301 Page Blvd.</b>					
3. NAME OF DECEASED a. (First) <b>Mary</b>			b. (Middle) _____		c. (Last) <b>Kuyath</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 2, 1952</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed 7</b>		8. DATE OF BIRTH <b>October 27, 1872</b>		9. AGE (In years last birthday) <b>79</b>	10. MONTHS <b>9</b>	11. DAYS <b>5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>John Schapp</b>			13b. MOTHER'S MAIDEN NAME <b>Not known</b>		14. NAME OF HUSBAND OR WIFE <b>John Kuyath</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Edwin G. Kuyath</b>				ADDRESS <b>2858 Texas Ave.</b>	
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) <b>CARDIO-VASCULAR-RENAL DISEASE</b>				INTERVAL BETWEEN ONSET AND DEATH _____	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension</b>					
				DUE TO (c) <b>Senility</b>					
				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"/>			
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>442X</b>					
22. I hereby certify that I attended the deceased from <b>April, 1936</b> , to <b>Aug, 1952</b> , that I last saw the deceased alive on <b>Aug. 1, 1952</b> , and that death occurred at <b>1:58</b> m., from the causes and on the date stated above.									
22a. SIGNATURE (Degree or title) <b>John B. O'Neill M.D.</b>				23b. ADDRESS <b>634 North Grand</b>		23c. DATE SIGNED _____			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8/5/52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>				
DATE REC'D BY LOCAL REG. <b>AUG 4 1952</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John H. Gebken Sons Und.Co. 2630 Gray Ave.</b>					

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 Robert F. Gebken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

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.