

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11870

FILED MAR 24 1953

State File No. _____

2396

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY 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 MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN ST. LOUIS MO)		c. LENGTH OF STAY (in this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2159		d. STREET ADDRESS (If rural, give location) 4466 BINGHAM	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4466 BINGHAM		4. DATE OF DEATH (Month) (Day) (Year) MAR. 2 1953	
3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) - KUPFERSCHMID c. (Last)		5. SEX FEMALE	
6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
8. DATE OF BIRTH AUG. 11 1864		9. AGE (In years last birthday) 88 IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIDOW		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME CHRIST RENZ		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE UNKNOWN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ANNA ECKRICH ADDRESS 4466 BINGHAM	
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) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH 1 week	
ANTECEDENT CAUSES (b) Upper Respiratory Infection		DUE TO (b)	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS (c) None		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 checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		4222	
22. I hereby certify that I attended the deceased from 2-24 1953 to 3/2/53 , 19____, that I last saw the deceased alive on 2/27/53 , 19____, and that death occurred at 1:30 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Dr. Harold MA.		23b. ADDRESS 5417 So Grand Blvd.	
23c. DATE SIGNED 3/3/53		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE MAR 5 1953		24c. NAME OF CEMETERY OR CREMATORY New ST MARCUS	
24d. LOCATION (City, town, or county) (State) ST. LOUIS MO		25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis ADDRESS 2906 Beavon	
DATE REC'D BY LOCAL REG. MAR 3 1953		REGISTRAR'S SIGNATURE J. Earl Smith, MD	

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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 Thomas E. Dill

Licensed Embalmer No. 4347

P. O. Address 2906 Harris

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.