

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**33557**  
State File No. ....  
**8946**

**1953 OCT 15 1953**      REG. DIST. NO. **318**      PRIMARY REG. DIST. NO. **1003**      Registrar's No. ....

|   |  |   |  |
|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).<br>a. STATE<br><b>Missouri</b><br>b. COUNTY |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>6201a S. Broadway</b>  |  | d. STREET ADDRESS (If rural, give location) <b>6201a S. Broadway</b>  |  |

|   |   |   |   |   |  |  |
|---|---|---|---|---|--|--|
| <b>3. NAME OF DECEASED</b><br>(Type or Print) <b>Theresa Kompst</b><br>a. (First)      b. (Middle)      c. (Last) |   |   | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)<br><b>Sept. 14, 1953</b> |   |  |  |
| <b>5. SEX</b><br><b>female</b>  | <b>6. COLOR OR RACE</b><br><b>white</b> | <b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify)<br><b>Widowed</b> | <b>8. DATE OF BIRTH</b><br><b>Apr. 25, 1881</b>                       | <b>9. AGE</b> (In years last birthday) <b>72</b>                          | <b>IF UNDER 1 YEAR</b><br>Months      Days | <b>IF UNDER 24 HRS.</b><br>Hours      Min. |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>None</b> |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>St. Louis, Mo.</b> |  | <b>12. CITIZEN OF WHAT COUNTRY?</b>        |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| <b>13a. FATHER'S NAME</b><br><b>Joseph Euge</b>  |  | <b>13b. MOTHER'S MAIDEN NAME</b><br><b>Clementine Mayhew</b> |  | <b>14. NAME OF HUSBAND OR WIFE</b><br><b>Hugo Kompst</b>                          |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b> |  | <b>16. SOCIAL SECURITY NO.</b><br><b>499-01-4711</b>         |  | <b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS<br><b>Asa Euge 3107 Chippewa</b> |  |

|   |   |  |   |
|---|---|--|---|
| <b>18. CAUSE OF DEATH</b><br>Enter only one cause per line for (a), (b), and (c)<br><br><i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i> | <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Coronary Thrombosis</b>  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b> |
|   | ANTECEDENT CAUSES<br><br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____ |  |   |
|   | <b>II. OTHER SIGNIFICANT CONDITIONS</b><br>Conditions contributing to the death but not related to the disease or condition causing death.                                |  |   |

|   |   |  |
|---|---|--|
| <b>19a. DATE OF OPERATION</b>                                 | <b>19b. MAJOR FINDINGS OF OPERATION</b>   | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| <b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)               | <b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)               | <b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>                                     |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) | <b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | <b>21f. HOW DID INJURY OCCUR?</b><br><b>4201</b>   |

**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** 10:40 P.M., **from the causes and on the date stated above.**

|  |                                    |  |  |
|--|------------------------------------|--|--|
| <b>23a. SIGNATURE</b><br><i>Victor L. Lyle, M.D.</i>               | (Degree or title) <b>3</b>         | <b>23b. ADDRESS</b><br><b>307 Clark</b>                            | <b>23c. DATE SIGNED</b><br><b>9/15/53</b>                                    |
| <b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Removal</b> | <b>24b. DATE</b><br><b>9-17-53</b> | <b>24c. NAME OF CEMETERY OR CREMATORY</b><br><b>Mt. Olive Cem.</b> | <b>24d. LOCATION</b> (City, town, or county) (State)<br><b>Lemay 23, Mo.</b> |

|   |  |   |  |
|---|--|---|--|
| <b>DATE REC'D BY LOCAL REG.</b><br><b>SEP 15 1953</b> | <b>REGISTRAR'S SIGNATURE</b><br><i>J. Earl Smith, M.D.</i> | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><i>Southern Funeral Home</i> | <b>ADDRESS</b><br><b>6322 S. Grand Blvd.</b> |
|---|--|---|--|

S.P. (Licensed Embalmer's Statement on Reverse Side)

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

300  
48

**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

*David Van Fossan*

Licensed Embalmer No. *4224*

P. O. Address. *6322 So. Lea*

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.