

FILED MAY 17 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17188

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4246

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>FIRMIN DESLOGE Hosp</u>			e. STREET ADDRESS (If rural, give location) <u>23 1003 ALLEN 2239</u>		
3. NAME OF DECEASED (Type or Print) <u>JACOB KAUSCH</u>			a. (First)	b. (Middle)	c. (Last)
4. DATE OF DEATH <u>MAY 9 1954</u>			(Month)	(Day)	(Year)
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>MAY 30 1883</u>		9. AGE (in years last birthday) <u>70</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED LABORER</u>	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>HUNGARY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>JOHN KAUSCH</u>		13b. MOTHER'S MAIDEN NAME <u>ROSE SCHICHEL</u>		14. NAME OF HUSBAND OR WIFE <u>LENA KAUSCH (DEC'D)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) _____		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>ADELE KAUSCH 1003 ALLEN</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>This does not mean the manner of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>			MEDICAL CERTIFICATION		
			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CARCINOMA of STOMACH</u>		
			ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
			II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>5/15/54</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Stomach.</u>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>151X</u>		
22. I hereby certify that I attended the deceased from <u>4/28</u> , 19 <u>54</u> , to <u>5/9</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>5/9/54</u> , 19____, and that death occurred at <u>6:09</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>A. J. Debrugne</u> (Degree or title) <u>M. D.</u>			23b. ADDRESS <u>1325 S. Grand</u>		23c. DATE SIGNED <u>5/9/54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>MAY 12 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>	24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>	
DATE REC'D BY LOCAL REG. <u>MAY 11 1954</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith mp</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kulis 2906 Harris</u>	

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

(Licensed Embalmer's Statement on Reverse Side)

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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.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No.....  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.