

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42549

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10496

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 township) OR TOWN St. Louis

c. CITY OR TOWN St. Louis

d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital

STREET ADDRESS (If rural, give location) 4542 Varrelmann Ave. 21590

3. NAME OF DECEASED (Type or Print)
a. (First) Vera b. (Middle) _____ c. (Last) Kurz

4. DATE OF DEATH (Month) (Day) (Year)
Nov. 16, 1954

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Oct. 13, 1885

9. AGE (In years last birthday) 69 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME ----- Kruse

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Otto Kurz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO. None

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Marge Brune - 4542 Varrelmann

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: *Biological Dyslipoproteinemia*
ANTECEDENT CAUSES: *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) *Retioferrous Malignancy*
DUE TO (c) *Lymph Glands Metastatic (to)*
II. OTHER SIGNIFICANT CONDITIONS
**Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH 5-6 wks

19a. DATE OF OPERATION 11/4/53

19b. MAJOR FINDINGS OF OPERATION *Cancer left breast*

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE 0 (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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 170X

22. I hereby certify that I attended the deceased from 6/27 1953, to 11/16, 1954, that I last saw the deceased alive on 11/16, 1954, and that death occurred at 2:25 P.M., from the causes and on the date stated above.

23a. SIGNATURE *H.R. Carter* (Degree or title) M.D.

23b. ADDRESS 6340 Grand

23c. DATE SIGNED 11/17/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE Nov. 19, 1954

24c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cemetery St. Louis Co., Missouri

24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. NOV 18 1954

REGISTRAR'S SIGNATURE *J. Carl Smith, M.D.*

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS *Wacker-Selders - 3634 Gravois Ave.*

WRITE PLAINLY—USING UNFADEING 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.....
Signature of Student Embalmer

Signed.....
Frank J. Gland

Licensed Embalmer No. *767*

P. O. Address *St Louis*

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.