

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 18 1955

43727

State File No. 11479

1003

318

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		REGISTRAR'S NO. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</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) <u>70 Yrs</u>		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>ST. LOUIS CITY HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>2029 6231 Goener Av</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>DORA</u> b. (Middle) _____ c. (Last) <u>KASSEBAUM</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>DECEMBER 15, 1954</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 26 1869</u>		9. AGE (In years last birthday) <u>85</u>	# UNDER 1 YEAR Months _____ Days _____	# UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Schlosswig Holstein, Germany</u>		12. CITIZENRY OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>Reimer Lucks</u>		13b. MOTHER'S MAIDEN NAME <u>Katherina Puls</u>		14. NAME OF HUSBAND OR WIFE <u>William F Kassebaum</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Miss Frieda Kassebaum 6231 Goener</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia infection</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Abdominal Genitral Surgery</u> DUE TO (c) <u>Carcinoma of rectum</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		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>154X</u>			
22. I hereby certify that I attended the deceased from <u>11-21-54</u> , 19 <u>54</u> , to <u>12-15-54</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>12-15-54</u> , 19 <u>54</u> , and that death occurred at <u>6:20P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>James K. Ottobrunn M.D.</u>				23b. ADDRESS <u>1515 Lafayette Avenue</u>		23c. DATE SIGNED <u>12-16-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Dec 18 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo</u>		
DATE REC'D BY LOCAL REG. <u>DEC 17 1954</u>		REGISTRAR'S SIGNATURE <u>Charles Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Beiderwieden F.H. Inc 1936 St. Louis Av</u>			

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 _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 452

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.**