

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 8 - 1955

State File No. **43757**
Registrar's No. **11713**

BIRTH NO. **96737-54** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ferguson 4649	
c. LENGTH OF STAY (in this place) 3 Days		d. STREET ADDRESS (If rural, give location) 111 Anastasia	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Debra b. (Middle) Ann c. (Last) Kuithe			4. DATE OF DEATH (Month) (Day) (Year) Dec. 23, 1954.		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Dec. 19, 1954	9. AGE (In years last birthday) 3	IF UNDER 1 YEAR Months 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nihil		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? U. S.A.					

13a. FATHER'S NAME Robert L. Kuithe Jr.	13b. MOTHER'S MAIDEN NAME Lorraine Meyer	14. NAME OF HUSBAND OR WIFE Single
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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 Robert L. Kuithe, Ferguson, Mo.	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CONGENITAL HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 2 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Developmental Anomaly		
	DUE TO (c) None		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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 type="checkbox"/>	21f. HOW DID INJURY OCCUR? 7544

22. I hereby certify that I attended the deceased from **Dec 19, 1954**, to **Dec 23, 1954**, that I last saw the deceased alive on **Dec 22, 1954**, and that death occurred at **12:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. G. H. Prideman M.D.	23b. ADDRESS 4126 S. Shrew Ave.	23c. DATE SIGNED 12/23/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12/24/54	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. DEC 24 1954	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE White Chapel, Ferguson, Mo.	ADDRESS
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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
Student Embalmer

Signed L. M. Shute

Licensed Embalmer No. 3973

P. O. Address Albuquerque, N.M.

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.