

FILED DEC 2 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38470

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10071

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 OR TOWN ST. LOUIS MO c. LENGTH OF STAY (in this place) \_\_\_\_\_  
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 3429 ITASKA e. STREET ADDRESS (If rural, give location) 15 3429 ITASKA

3. NAME OF DECEASED (Type or Print) a. (First) MARGARET b. (Middle) \_\_\_\_\_ c. (Last) KINLE 4. DATE OF DEATH (Month) (Day) (Year) Nov. 17 1955

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW 8. DATE OF BIRTH MAR. 14 1870 9. AGE (in years last birthday) 85 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) WIDOW 10b. KIND OF BUSINESS OR INDUSTRY AT HOME 11. BIRTHPLACE (City and State or Foreign Country) MO. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME AUGUST STAHLMANN 13b. MOTHER'S MAIDEN NAME UNKNOWN 14. NAME OF HUSBAND OR WIFE JOHN H. KINLE (DEC'D)

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. NONE 17. INFORMANT'S SIGNATURE OR NAME MAYME KINLE ADDRESS 3429 ITASKA

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Myocarditis Chronic  
\*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.  
ANTECEDENT CAUSES DUE TO (b) Genl Arteriosclerosis  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (c) \_\_\_\_\_  
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 422.1 20. AUTOPSY? YES  NO

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  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from 10/32, 1955, to 11/17, 1955, that I last saw the deceased alive on 11/16, 1955, and that death occurred at 5:15 AM., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) K. Naechuy MD 23b. ADDRESS 4703 Virginia 23c. DATE SIGNED 11/18/55

24a. BURIAL, CREMATION REMOVAL (Specify) REMOVAL 24b. DATE NOV 21 1955 24c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL 24d. LOCATION (City, town, or county) (State) ST. LOUIS MO

DATE REC'D BY LOCAL REG. NOV 18 1955 REGISTRAR'S SIGNATURE J. Carl Smith MD 25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kates 2916 Beavois ADDRESS \_\_\_\_\_

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

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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..... *Samuel C. Hill*

Licensed Embalmer No..... *434*

P. O. Address..... *2906 Hill*

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.