

FILED MAR 2-2 1956

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 10968

318

PRIMARY REG. DIST. NO.

1003

Registrar's No. 2468

BIRTH NO.

REG. DIST. NO.

## 1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, write RURAL and give OR TOWN **ST. LOUIS, MISSOURI** (township)

c. LENGTH OF STAY (in this place)

## 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE

**Missouri**

b. COUNTY

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 (If not in hospital or institution, give street address or location) **ST. LOUIS CITY HOSPITAL #1.**

e. STREET ADDRESS

(If rural, give location)

**1228 No. 9th St.**

## 3. NAME OF DECEASED (Type or Print)

a. (First)

**JOHN**

b. (Middle)

**J.**

c. (Last)

**KIEL**

4. DATE OF DEATH

(Month)

(Day)

(Year)

**MARCH 8, 1956.**

## 5. SEX

**Male**

## 6. COLOR OR RACE

**White**

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

**Widowed**

## 8. DATE OF BIRTH

**May 4-1893**

## 9. AGE (In years last birthday)

**62**

## IF UNDER 1 YEAR

Months

## IF UNDER 24 HRS.

Days

## Hours

Min.

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

**Clerk**

## 10b. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (City and State or Foreign Country)

**St. Louis, Mo.**

## 12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

## 13a. FATHER'S NAME

**John Kiel**

## 13b. MOTHER'S MAIDEN NAME

**unknown**

## 14. NAME OF HUSBAND OR WIFE

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

**Yes**

## 16. SOCIAL SECURITY NO. (If yes, give war or date of service)

**W.W.#1**

## 17. INFORMANT'S SIGNATURE OR NAME

**John L. Kiel**

## ADDRESS

**1228 N. 9th St.**

## 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.

## I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a)

**ARTERIOSCLEROTIC Heart Disease**

## ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

**Refractory Congestive Failure**

DUE TO (c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

**Generalized Arteriosclerosis**

## INTERVAL BETWEEN ONSET AND DEATH

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

**420.0**

## 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)

(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 **2-28**, **1956**, to **3-8**, **1956**, that I last saw the deceased alive on **3-8**, **1956**, and that death occurred at **8:20 A.M.**, from the causes and on the date stated above.

## 23. SIGNATURE (Type or Print)

**Martin G. Austin M.D.**

## 23b. ADDRESS

**1515 LAFAYETTE AVE.**

## 23c. DATE SIGNED

**3-8-56.**

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

**Removal**

## 24b. DATE

**3/12/56**

## 24c. NAME OF CEMETERY OR CREMATORY

**Memorial Park Cemetery**

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

**St. Louis Co., Mo.**

## DATE REC'D BY LOCAL REG.

**MAR 9 1956**

## REGISTRAR'S SIGNATURE

**J. Earl Smith, M.D.**

## 25. FUNERAL DIRECTOR'S SIGNATURE

**Sullivan's 2849 N. Euclid Ave.**

## ADDRESS

---

---

**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.....  
*Albert Mayfield*  
Licensed Embalmer No. 50

P. O. Address.....

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (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.