

FILED MAY 25 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **18128**  
Registrar's No. **4142**

BIRTH NO. \_\_\_\_\_ 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 <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN <b>ST. LOUIS Mo</b> )		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>ST. LOUIS</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ALEXIAN BROS. Hosp.</b>		e. STREET ADDRESS (If rural, give location) <b>23 2833 SIDNEY ST.</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>ANDREW</b> b. (Middle) <b>KERSTING</b> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <b>APRIL 24 1956</b>		
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5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>NOV. 7 1888</b>		9. AGE (In years last birthday) <b>67</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSURANCE SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MIDWEST INS.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>ST. LOUIS Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U-S-A.</b>	
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13a. FATHER'S NAME <b>JOHN KERSTING</b>		13b. MOTHER'S MAIDEN NAME <b>UNKN.</b>		14. NAME OF <del>husband</del> OR WIFE <b>JOSEPHINE KERSTING</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>492-09-0259</b>		17. INFORMANT'S SIGNATURE OR NAME <b>JOSEPHINE KERSTING</b> ADDRESS <b>2833 SIDNEY</b>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Extensive Coronary Thrombosis</b>		DUE TO (b) <b>Myocarditis Ch. Myocardium</b>				<b>2 days</b>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <b>Arteriosclerosis</b>				<b>5 yrs.</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Coronary infarction</b>						<b>5 days.</b>	

19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION <b>None</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>None</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>None</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **July 6 1951**, to **Apr. 24 1956** that I last saw the deceased alive on **Apr. 27 1956** and that death occurred at **7:50 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Dr. J. Paul Smith M.D.</b>		23b. ADDRESS <b>2767 Gravois Ave</b>		23c. DATE SIGNED <b>4-26-56</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>APR. 27 1956</b>		24c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEM.</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Mo</b>	
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DATE REC'D BY LOCAL REG. <b>APR 26 1956</b>		REGISTRAR'S SIGNATURE <b>J. Paul Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas Kuter</b> ADDRESS <b>2906 Gravois</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2-8-0310

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 *2506*

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.