

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28651**
Registrar's No. **6843**

FILED AUG 24 1956

318

1003

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 Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 5yrs		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5849 Walsh Street				e. STREET ADDRESS (If rural, give location) 14 5849 Walsh Street			
3. NAME OF DECEASED (Type or Print) a. (First) Lisette b. (Middle) Kefrig c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) 7 - 20 - 1956				
5. SEX Fem	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1 - 8 - 1866		9. AGE (In years, last birthday) 90	IF UNDER 1 YEAR Days _____	IF UNDER 6 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and State or Foreign Country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME unknown Duing		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Herman H. Kefrig			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Wm. Warmbold, 5849 Walsh 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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral hemorrhage due ANTECEDENT CAUSE Morbid conditions, if any, giving rise to the above (a) as well as the underlying cause (a). DUE TO (b) General arteriosclerosis and hypertension. DUE TO (c) _____ OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1 hour ?	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 331x			
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? _____			
22. I hereby certify that I attended the deceased from 7/20 , 1956, to 7/20 , 1956, that I last saw the deceased alive on 7/20 , 1956, and that death occurred at 12 noon , from the causes and on the date stated above.							
23a. SIGNATURE W. J. Neun MD. (Degree or title) _____				23b. ADDRESS 5203 Chippewa Street		23c. DATE SIGNED 7/21/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7/23/56	24c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.		
DATE REC'D BY LOCAL REG. III 23 1956		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harral 1905 Union Blvd.			

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Neun
5203 Chippewa

Sat. 10 - 12
Mon. 2 - 5

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 R. Thompson*

Licensed Embalmer No. *42*

P. O. Address..... *St. Louis*

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.