

FILED NOV 16 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35727**
Registrar's No. **9118**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 35727		Registrar's No. 9118	
1. PLACE OF DEATH a. COUNTY Missouri				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) 5M 16da		c. CITY OR TOWN St. Louis		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Chronic Hospital				e. STREET ADDRESS (If rural, give location) 20/9 316 West Primm					
3. NAME OF DECEASED (Type or Print) a. (First) Amalia b. (Middle) _____ c. (Last) Kast			4. DATE OF DEATH (Month) (Day) (Year) 10/4/56						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 9/21/70		9. AGE (In years last birthday) 86	10 UNDER 1 YEAR Months _____ Days _____	10 OVER 1 YEAR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Equivius Mueller			13b. MOTHER'S MAIDEN NAME Eva Frank		14. NAME OF HUSBAND OR WIFE Thomas Kast				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unk		17. INFORMANT'S SIGNATURE OR NAME Chronic Hospital, 5600 Arsenal ADDRESS _____					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH		
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES Morbid conditions of any kind rising due to (b) Generalized Arteriosclerosis rise to the above cause by creating the underlying cause last. DUE TO (c) _____								
	2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Intertrochanteric Fracture Left Femur						1 1/4 months		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____							
21a. ACCIDENT SUICIDE HOMICIDE (Specify) ACCIDENT		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ST. LOUIS CHRONIC HOSP.		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) ST. LOUIS MISSOURI		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-26-1956 12:20 P.M.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? PATIENT FOUND IN BED WITH PAIN, SWELLING & DISCOLORATION					
22. I hereby certify that I attended the deceased from 4/18 , 19 56 to 10/4 , 19 56 , that I last saw the deceased alive on 10/4 , 19 56 , and that death occurred at 3:35 P.M. , from the causes and on the date stated above.									
23a. SIGNATURE George M. Janaka, M.D. (Degree or title)				23b. ADDRESS 5600 Arsenal			23c. DATE SIGNED 10/5/56		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct. 6, 1956	24c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.		24d. LOCATION (City, town, or county) (State) Lemay 23, Mo.				
DATE REC'D BY LOCAL REG. OCT 5 1956		REGISTRAR'S SIGNATURE Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home			ADDRESS 6322 S. Grand Blvd., St. Louis, Mo.		

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.....
Signature of Student Embalmer

Signed *David T. Johnson*.....
Licensed Embalmer No. *434*.....
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.