

FILED JAN 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **43297**BIRTH NO. **73499-56** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8124**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		c. CITY OR TOWN Flor'dell Hills 4149 d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) J c. (Last) Kaelin		4. DATE OF DEATH (Month) (Day) (Year) Aug 31 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Aug 19 1956
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, Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Paul Kaelin	
13b. MOTHER'S MAIDEN NAME Blanche Doere		14. NAME OF HUSBAND OR WIFE NONE	
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. _____	
17. INFORMANT'S SIGNATURE OR NAME Mr. Paul Kaelin		ADDRESS 7035 Brandon	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Infection - ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Dehydration + acidosis DUE TO (c) Pneumonia + congenital heart disease + diabetes	
INTERVAL BETWEEN ONSET AND DEATH 1 day - 2 days 14 days		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION As above	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		754.4	
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) (Min.)	
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 Aug 29, 1956 , to Aug 31, 1956 , that I last saw the deceased alive on Aug 31, 1956 , and that death occurred at 9:30 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE W. C. Gust		23b. ADDRESS (Degree or title) M. D. 8700 Riverview	
23c. DATE SIGNED 9-1-56		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 9-3-56		24c. NAME OF CEMETERY OR CREMATORY Calvary	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JOHN STYGAR & SON = 5541 RIVERVIEW BLVD.	
DATE REC'D BY LOCAL REG. SEP 4 1956		REGISTRAR'S SIGNATURE Paul Smith MD	

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.....
Licensed Embalmer No. 3980
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.