FILED JUN 26 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

57 022654

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5759

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Mo. Baptist Hosp. — Length of stay in Ib: 80yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY:
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☒ No ☐
STREET ADDRESS (If outside, give location): 6171 McPherson — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Josephine; Middle: Drescher; Last: Kotsrean

4. DATE OF DEATH: Month June, Day 19, Year 1957

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 14, 1856
9. AGE (In years last birthday): 100 yrs — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 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: Home
11. BIRTHPLACE (City and state or country): Milwaukee, Wisc.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Drescher
14. MOTHER'S MAIDEN NAME: Faber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. William J. Kotsrean — Address: 6171 McPherson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): CEREBRAL ARTERIOSCLEROSIS — INDET
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 332x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from JUNE 2, 1955, to JUNE 19, 1957 and last saw her/him alive on 19 JUNE 1957
Death occurred at 8-45 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Robert A. Mayer (Degree or title) M.D.
22b. ADDRESS: 567 NORTH SOUTHRY UNIVERSITY CITY 5, Mo.
22c. DATE SIGNED: 6/26/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: June 21, 1957
23c. NAME OF CEMETERY OR CREMATORY: New Pickers Cemetery
23d. LOCATION (City, town, or county): St. Louis, (State) Mo.

24. FUNERAL DIRECTOR: Alexander & Sons — ADDRESS: 6125 Delmar
25. DATE RECD. BY LOCAL REG.: JUN 20 '57
26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. S.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related.

Dr Mazer
N+S & Delmar at 1
VO 3-7388

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Jos E McCullah

Licensed Embalmer No. 24

P. O. Address 6175 R

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.