

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 4 1957

State File No. **30443**  
Registrar's No. **1887**

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <b>317</b>  |  | PRIMARY REG. DIST. NO. <b>500</b>   |  | Registrar's No. <b>1887</b>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give town) <b>Cool Valley</b>  |  | c. LENGTH OF STAY (If in institution) <b>2 Wks. 2 days</b>                                     |  | c. CITY OR TOWN <b>Kirkwood</b>   |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Hilltop House Nursing Home</b>  |  |  |  | e. STREET ADDRESS (If rural, give location) <b>544 S. Harrison</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Theodore,</b>   |  | b. (Middle) <b>Wm.</b>   |  | c. (Last) <b>Kostedt</b>  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>July 28, 1957</b>  |  |
| 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>Sept. 15, 1894</b> |   | 9. AGE (In years, month, days, hours, min.)<br><b>62</b> | IF UNDER 1 YEAR<br>Months _____ Days _____   | IF UNDER 11 YRS.<br>Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, or as retired) <b>Fireman-retired</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>City of Kirkwood</b>                                      |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>St. Charles, Mo.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13a. FATHER'S NAME <b>Wm. Kostedt</b>  |  | 13b. MOTHER'S MAIDEN NAME <b>Mary Wehmeyer</b>   |  | 14. NAME OF HUSBAND OR WIFE <b>Frances Kostedt</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) <b>Yes World War One</b>   |  | 16. SOCIAL SECURITY NO. <b>None</b>  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Frances Kostedt, 544 S. Harrison</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Metastatic carcinoma of brain</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Carcinoma of Lung, Primary</b><br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b>   |  |
| 19a. DATE OF OPERATION _____   | 19b. MAJOR FINDINGS OF OPERATION<br><b>1) Ca. lung; 2) Brain metastases 162x</b>   |  |  |   |  | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 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) _____  | 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 <b>July 12, 1957</b> , to <b>July 28, 1957</b> , that I last saw the deceased alive on <b>July 28, 1957</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above. |  |  |  |   |  |  |  |
| 23a. SIGNATURE (Degree or title) <b>Blue G. McJury M.D.</b>  |  |  |  | 23b. ADDRESS <b>5017 Thebela Av.</b>  |  | 23c. DATE SIGNED <b>7/28/57</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 24b. DATE <b>7/31/57</b>   | 24c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>                                    |  | 24d. LOCATION (City, town, or county) (State) <b>Jefferson Brks, Mo.</b>  |  |  |  |
| DATE REC'D BY LOCAL REG. <b>7-29-57</b>  |  | REGISTRAR'S SIGNATURE <b>Hubert R. Conkle M.D.</b>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Mo. Pfizinger Mortuary, Inc., Kirkwood,</b>   |  |  |  |

(License of Registrar's Statement on Reverse Side)

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

No. 300  
10-48

**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 *William A. Putney*.....  
Licensed Embalmer No. ....  
P. O. Address .....

**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.**