

FILED SEP 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33754

Registration District No. **318** Primary Registration District No. **1003** STATE FILE NUMBER **8528**
Registrar's No. **8528**

1. PLACE OF DEATH
a. COUNTY _____

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **ST. LOUIS Mo** Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **ENROUTE CITY HOSPITAL** Length of stay in 1b **38**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **ILLINOIS** COUNTY _____
b. CITY OR TOWN **BELLEVILLE Mo** Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) **170 CHEVY CHASE** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) **MARTIN** First **KRISTOF** Middle **KRISTOF** Last

4. DATE OF DEATH **SEPT 9 1957** Month **SEPT** Day **9** Year **1957**

5. SEX **MALE** 6. COLOR OR RACE **WHITE** 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH **OCT 16 1903** 9. AGE (In years' last birthday) **53**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **FOREMAN** 10b. KIND OF BUSINESS OR INDUSTRY **HEIMBERGER BODY** 11. BIRTHPLACE (City and state or country) **ROUMANIA** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **ANTHONY KRISTOF** 14. MOTHER'S MAIDEN NAME **UNKNOWN**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **No** (If yes, give war or dates of service) _____

16. SOCIAL SECURITY NO. **492-01-3026** 17. INFORMANT **MARTHA KRISTOF** Address **BELLEVILLE ILL.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Internal Hemorrhage**
DUE TO (b) **Multiple Fractures of ribs.**
DUE TO (c) _____

CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____

19. WAS AUTOPSY PERFORMED? YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT SUICIDE HOMICIDE 20b. DEGREE AND HOW INJURY OCCURRED (Give nature of injury in Part I or Part II (a) or (b)) **suffered in fall from ladder while in apartment crushing skull about 2:20 pm.**

20c. TIME OF INJURY Hour **2:20** Month **9** Day **9** Year **1957** **September 9 1957** E901:69

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.) **23 Building** 20f. CITY, TOWN OR LOCATION **St Louis Mo** COUNTY _____ STATE _____

21. I attended the deceased from **545 P.** to _____ and last saw her/him alive on _____ month occurred at _____

22a. SIGNATURE **Joseph J. [Signature]** (Degree or title) **Deputy** 22b. ADDRESS **1300 Clark** 22c. DATE SIGNED **9/11/57**

23a. BURIAL, CREMATION, REMOVAL (Specify) **REMOVAL** 23b. DATE **SEPT 17 1957** 23c. NAME OF CEMETERY OR CREMATORY **MT HOPE CEM.** 23d. LOCATION (City, town, or county) (State) **ST. LOUIS CO. Mo.**

24. FUNERAL DIRECTOR **Thomas Kutis 2906 Gravois** ADDRESS _____ 25. DATE RECD. BY LOCAL REG. **SEP 11 57** 26. REGISTRAR'S SIGNATURE **J. Carl Smith Mo**

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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MISSOURI DEPARTMENT OF HEALTH - DIVISION OF HEALTH - ST. LOUIS, MISSOURI

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by Student Embalmer No.....
working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 31

P. O. Address St. Louis

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.