

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 28 1957

STATE FILE NUMBER **37675**
Registrar's No. **9338**

Registration District No. **318** Primary Registration District No. **1003**

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Affton 4000
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 9031 Kathleen
3. NAME OF DECEASED (Type or print) First Frank Middle Last Kasl			4. DATE OF DEATH Month October Day 4 Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY Farming	9. AGE (In years last birthday) 84 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
11. BIRTHPLACE (City and state or country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Frank Kasl		13b. MOTHER'S MAIDEN NAME (Unknown) Schober	
14. NAME OF HUSBAND OR WIFE Unavailable		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil.	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Frank Kasl Jr. O'Fallon, Missouri.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pyelonephritis			INTERVAL BETWEEN ONSET AND DEATH unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 600.0			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		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. _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
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 9-29-57 to 10-4-57 and last saw him alive on 10-4-57 Death occurred at 4:20p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James M. Masterson M.D.		22b. ADDRESS 1515 Lafayette	
22c. DATE SIGNED 10-4-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-5-57	
23c. NAME OF CEMETERY OR CREMATORY Assumption Cemetery		23d. LOCATION (City, town, or county) (State) O'Fallon, Missouri.	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. OCT 7 '57	
26. REGISTRAR'S SIGNATURE Carl Smith MO			

OCT 28 1957

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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 *Stanley H. Dixon*

Licensed Embalmer No. *4193*

P. O. Address *St. L.*

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.