

FILED JAN 27 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

47586  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12133

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>Kirkwood</u> <u>46730</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>1027 Meadowridge Dr</u>	
3. NAME OF DECEASED (Type or print) First <u>PETER</u> Middle <u>E.</u> Last <u>KISSGEN</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Staff Purchasing Agent - Falstaff Brewing Co.</u>		11. BIRTHPLACE (City and state or country) <u>New Orleans, La.</u>	
13a. FATHER'S NAME <u>Peter J. Kissgen</u>		14. NAME OF HUSBAND OR WIFE <u>Lorraine Kissgen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give year or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>433-01-1629</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion with myocardial infarction</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>	
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <u>11/7/57</u> to <u>12/16/57</u> and last saw him alive on <u>12/9/57</u> Death occurred <u>1:45 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		22. SIGNATURE <u>Morris Olex...</u> 22b. ADDRESS <u>601 Humboldt Bldg</u> 22c. DATE SIGNED <u>12/17/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
<u>(Rail) 12-19-57</u>		<u>12-19-57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lafayette Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>New Orleans, La.</u>	
24. FUNERAL DIRECTOR <u>Kriegshauser 4228 S. Kingshighway</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 17 57</u>	
26. REGISTRAR'S SIGNATURE <u>J. Carl Smith mo</u>		27. <u>m86</u>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

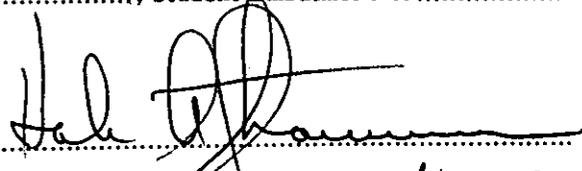
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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. 4533 .....  
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.