

Health,  
& Welfare  
Public  
Service

FILED MAY 1 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-016047  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3868

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>01 2627 Keokuk St.</u>		Length of stay in lb <u>2 4/4</u>	d. STREET ADDRESS (If outside, give location) <u>2627 Keokuk St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>FRANCES</u> Last <u>0 KRAWINKEL</u>			4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1958</u>		
5. SEX <u>female</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>Sept. 3, 1936</u>		9. AGE (In years last birthday) <u>21 yrs.</u> IF UNDER 1 YEAR: Months <u>7</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>

13a. FATHER'S NAME <u>Paul Dobberstein</u>	13b. MOTHER'S MAIDEN NAME <u>Frances Doerhoff</u>	14. NAME OF HUSBAND OR WIFE <u>Bernard R. Krawinkel</u>
---	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>499-36-8258</u>	17. INFORMANT <u>Bernard R. Krawinkel</u> Address <u>2627 Keokuk St.</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>Adenocarcinoma of pancreas</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>
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)		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.) <u>157x</u>	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		
20d. INJURY OCCURRED WHILE AT WORK <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 <u>Dec 2, 1957</u> to <u>present</u> and last saw her alive on <u>April 3, 1958</u> Death occurred at <u>3 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Robert C. Hurligand MD</u>	22b. ADDRESS <u>14 Front St. W. Clayton, Mo</u>	22c. DATE SIGNED <u>4-7-58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Apr. 8, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
--	----------------------------------	---	---

24. FUNERAL DIRECTOR <u>Gebken Mortuary, 2630 Gravois Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>APR 7 '58</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>m83</u>
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Medical Certification  
All diseases in Part I must be causally related.

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 *Gustav W. Dieter* .....

Licensed Embalmer No. *4329* .....

P. O. Address *St. Louis Mo* .....

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.