

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-019847
STATE FILE NUMBER

FILED MAY 28 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5327

5. 300
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis, Mo.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) OF HOSPITAL OR INSTITUTION <i>3867 Shaw Ave</i>		Length of stay in 1b <i>2 1/2</i>	d. STREET ADDRESS (If outside, give location) <i>3867 Shaw Ave</i>		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Josephine Kauflin</i>			4. DATE OF DEATH Month Day Year <i>5-20-58</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-12-1876</i> 1893	9. AGE (In years last birthday) <i>81</i> 64	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Kept House</i>	11. BIRTHPLACE (City and state or country) <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13a. FATHER'S NAME <i>Charles Niehaus</i>		13b. MOTHER'S MAIDEN NAME <i>Jane Abbink</i>		14. NAME OF HUSBAND OR WIFE <i>Frederich Kauflin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>----</i>	17. INFORMANT Address <i>Mrs. Cressie Ober 3867 Shaw Ave</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis -</i> DUE TO (b) <i>Arterio-sclerotic Disease</i> DUE TO (c) <i>several</i>					INTERVAL BETWEEN ONSET AND DEATH <i>about 2 years</i> <i>years -</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>422.1</i>					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 Month, Day, Year 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 <i>June 10-57</i> to <i>May 20-1958</i> and last saw her alive on <i>May 20-1958</i> Death occurred at <i>6:20 A.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Dr. M. D. D.</i>			22b. ADDRESS <i>3606 Davies Ave</i>		22c. DATE SIGNED <i>5/20/58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-21-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Weick Bros 2201 S. Grand Blvd</i>			25. DATE RECD. BY LOCAL REG. <i>MAY 20 1958</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith Mo</i> <i>ms</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Collected by affidavit 5/28/58

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.

Dr. W. Heinichus
3606 Grand - 2-4

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 *Harvey Kahle*

Licensed Embalmer No. *4596*
P. O. Address *Flouissant*

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.