

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032129  
STATE FILE NUMBER

FILED SEP 29 1958

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 281

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>COLE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>St. Louis City</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JEFFERSON CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis, MO</u> <u>2239</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CHAS. E. Still Hosp</u>		Length of stay in lb <u>24 hrs</u>	d. STREET ADDRESS (If outside, give location) <u>1833 Schild AVE</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>EMIL</u> Middle <u>Anthony</u> Last <u>KRISTEN</u>			4. DATE OF DEATH Month <u>SEPT.</u> Day <u>20</u> Year <u>1958</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</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>JUNE 6, 1903</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>PRINTING</u>	11. BIRTHPLACE (City and state or country) <u>HUNGARY</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
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13a. FATHER'S NAME <u>JOSEPH KRISTEN</u>	13b. MOTHER'S MAIDEN NAME <u>ANNA FURLAN</u>	14. NAME OF HUSBAND OR WIFE <u>OMA JONES KRISTEN</u>
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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>491-34-0435</u>	17. INFORMANT <u>OMA KRISTEN</u>	Address <u>St. Louis, MO.</u>
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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>Medullary Paralysis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days -</u> <u>5 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Proximal cerebral hemorrhage</u>	
	DUE TO (c) <u>Arteriosclerosis - Essential Hypertension</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u>		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 <u>  </u> Month, Day, Year a.m. <u>  </u> p.m. <u>  </u>	

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 <u>JEFFERSON CITY, MO.</u>	COUNTY <u>  </u>	STATE <u>  </u>
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21. I attended the deceased from <u>9/17/58</u> to <u>9/20/58</u> and last saw her alive on <u>9/20/58</u> Death occurred at <u>9</u> <u>PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Lawrence E. Doffen DO<sup>2</sup></u>	(Degree or title)	22b. ADDRESS <u>Jefferson City, Mo.</u>	22c. DATE SIGNED <u>9-22-1958</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT. 23, 1958</u>	23c. NAME OF CEMETERY OR CREMATOR <u>Eldon</u>	23d. LOCATION (City, town, or county) (State) <u>Eldon MO.</u>
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24. FUNERAL DIRECTOR <u>Louis N. Phillips</u>	ADDRESS <u>Eldon</u>	25. DATE RECD. BY LOCAL REG. <u>22 September '58</u>	26. REGISTRAR'S SIGNATURE <u>R. P. Davis, MD-MR.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

1958 9 7

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 *Louis D. Phillips*

Licensed Embalmer No. *3663*

P. O. Address *Calder*

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.