Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

58-042757
STATE FILE NUMBER

FILED NOV 20 1958 Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2720

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN Wellston — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Rock wood Manor Rest Home — Length of stay in Ib 1 Year

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 5533 Vernon Ave. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First SARAH Middle J. Last KINDER

4. DATE OF DEATH Month Oct. Day 27 Year 1958

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH April 12, 1879
9. AGE (In years last birthday) 79 — 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) Housework
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (City and state or country) Gillespie, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Gerhardt Bohlken
13b. MOTHER'S MAIDEN NAME Marika Albers
14. NAME OF HUSBAND OR WIFE Late Neal Kinder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT Lucille Ahearn Address 5047a Chippewa St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH 3 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Medullary Failure — 3 min.
DUE TO (c) Cerebral Encephalomalacia 332X — 3 weeks.
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 ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 March 1958, to Oct 27, 1958 and last saw her/him alive on Oct 27, 1958
Death occurred at 4:28 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Martin Klaus M.D. (Degree or title)
22b. ADDRESS 5507 Pershing
22c. DATE SIGNED 10/29/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Oct. 30, 1958
23c. NAME OF CEMETERY OR CREMATORY Hiram Park Cemetery
23d. LOCATION (City, town, or county) St. Louis Co. (State) Mo.

24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S. Kingshighway
25. DATE RECD. BY LOCAL REG. 10-29-58
26. REGISTRAR'S SIGNATURE Herbert A. Domke M.D.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 William B. White

Licensed Embalmer No. 4291

P. O. Address 4228 Kingsbridge

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.