Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003185
STATE FILE NUMBER

FILED FEB 3 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 595

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: Faith Hospital — Length of stay in 1b: 6 weeks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS: 4946a W. Florissant (If outside, give location) — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Minnie — Middle: E — Last: Kurlbaum
4. DATE OF DEATH: Month: Jan — Day: 16 — Year: 1959
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: July 17 1898
9. AGE (In years last birthday): 60 — 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): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: Robert Flieger
13b. MOTHER'S MAIDEN NAME: Marie Bachmann
14. NAME OF HUSBAND OR WIFE: Edw. H. Kurlbaum, (Deceased)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Chas. E. Busen, Address: 6201 Emma Avenue

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) Carcinomatosis Ca Breast — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
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): 170X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 5/2/57, to 1/16/59 and last saw her alive on 1/16/59
Death occurred at 10:10 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Robert A. Bauer MD (Degree or title)
22b. ADDRESS: 3731 Goodfellow
22c. DATE SIGNED: 1/17/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Jan. 20, 1959
23c. NAME OF CEMETERY OR CREMATORY: New Bethlehem Cemetery
23d. LOCATION (City, town, or county): St. Louis County (State): Missouri

24. FUNERAL DIRECTOR: Math Hermann & Son, Inc., ADDRESS: 2161 E. Fair
25. DATE RECD. BY LOCAL REG.: JAN 19 '59
26. REGISTRAR'S SIGNATURE: J. Earl Smith M.D. M. J. B.

(Licensed Embalmer's Statement on Reverse Side)

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

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 Clement M. McNeny

Licensed Embalmer No. 3792

P. O. Address St. Louis

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.