Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-006640
STATE FILE NUMBER

FILED FEB 19 1959

Registration District No. 276 Primary Registration District No. 5945 Registrar's No. 78

1. PLACE OF DEATH
a. COUNTY: Phelps
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): ST. JAMES - RURAL — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Ferndale Rest Home — Length of stay in 1b: 3yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: City
c. CITY OR TOWN: ST. LOUIS 2009 — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Frank Middle: Last: KAUP
4. DATE OF DEATH: Month 2 Day 12 Year 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-9-1877
9. AGE (In years last birthday): 71 — 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): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Fred Kaup
13b. MOTHER'S MAIDEN NAME: Sophia Hammerson
14. NAME OF HUSBAND OR WIFE:

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.: None
17. INFORMANT: Anna S. Apple — Address: 2838 Hayo - St. Louis, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Hypertensession about	6 years
DUE TO (c)	Bronchial complications	3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331X

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 7-7.1955 to 2-12.'59 and last saw him alive on 2-11.1959
Death occurred at 2-12.1959 — 1:25 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C.V. Hammler, M.D. (Degree or title)
22b. ADDRESS: St. James, Mo.
22c. DATE SIGNED: 2-14.'59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2-13-59
23c. NAME OF CEMETERY OR CREMATORY: Lake Charles Cem.
23d. LOCATION (City, town, or county) (State): St. Louis, Co. Mo.

24. FUNERAL DIRECTOR: Oral E. Lichlidin — ADDRESS: St James Mo.
25. DATE RECD. BY LOCAL REG.: 2-16-59
26. REGISTRAR'S SIGNATURE: Ruth B. Prowell

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

VS MAR 5 1957

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 ....me...., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Orae E. Lickliter

Licensed Embalmer No. 3546

P. O. Address St James 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.