

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007295
STATE FILE NUMBER
2-1839
Registrar's No.

FILED MAR 10 1959 Registration District No. Primary Registration District No.

300
1-57
49
6

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Altenheim		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 5408 S Bdway

3. NAME OF DECEASED (Type or print) First Middle Last Kate Kauten			4. DATE OF DEATH Month Day Year 2-19-59	
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-29-68	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) HUNGARY	12. CITIZEN OF WHAT COUNTRY? 6 USA
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13a. FATHER'S NAME JOHN KAUTEN	13b. MOTHER'S MAIDEN NAME MARY	14. NAME OF HUSBAND OR WIFE JACOB KAUTEN
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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) NO	16. SOCIAL SECURITY NO. UNK	17. INFORMANT KATE HIRSON BECK 1054 N. DICKSON	Address
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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) Cerebral Hemorrhage.		INTERVAL BETWEEN ONSET AND DEATH 1 day 6 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) arterio sclerosis and hypertension	
	DUE TO (c) 331X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) arterio sclerosis heart disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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.) St. Louis	20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis MO
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21. I attended the deceased from Dec 15 1934 to Feb 19 1959 and last saw her alive on Feb 18 1959 Death occurred at Feb 19 1959 12:40 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Max Stabloff M.D.	(Degree or title)	22b. ADDRESS 512 Dorow Place	22c. DATE SIGNED 2/19/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/20/59	23c. NAME OF CEMETERY OR CREMATORY St. Peter and Paul	23d. LOCATION (City, town, or county) St. Louis Missouri
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24. FUNERAL DIRECTOR Edward Fendler 5611 South Grand Blvd.	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE Lead Smith M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Hasley F. Koelb*

Licensed Embalmer No. *4950*
P. O. Address *St. Paul*

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.