Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 59-007306

FILED MAR 9 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1612

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST LOUIS — Inside Limits Yes ☐ No ☐ c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): LITTLE SISTER OF THE POOR — Length of stay in Hospital: 4	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Mo — b. COUNTY: St Louis c. CITY OR TOWN: AFFTON 4810 — Inside Limits Yes ☐ No ☐ d. STREET ADDRESS (If outside, give location): 5019 FRANKFORT — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: IDA — Middle: A — Last: KELSEY

4. DATE OF DEATH: Month: FEB — Day: 13, — Year: 1959

5. SEX: FEMALE 1

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 2

8. DATE OF BIRTH: November 21, 1875

9. AGE (In years last birthday): 83 — 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): AT HOME

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): GOSHEN, INDIANA 1

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: HOOVENS

13b. MOTHER'S MAIDEN NAME: NOT KNOWN

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS C A BROEMSER — Address: 822 So CLARK MEXICO, 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)	Arteriosclerotic Heart Dis	yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Gen. Arteriosclerosis	yrs.
DUE TO (c)	420.0	

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: 2/13/59 St Louis, Mo — COUNTY — STATE

21. I attended the deceased from Jan 1959, to 2/13/59 and last saw her/him alive on 2/9/59
Death occurred at 8 PM, m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [illegible] (Degree or title): MD — 22b. ADDRESS: 8059 Watson Rd — 22c. DATE SIGNED: 3/14/59

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL — 23b. DATE: 2/17/59 — 23c. NAME OF CEMETERY OR CREMATORY: SUNSET BURIAL PARK — 23d. LOCATION (City, town, or county) (State): AFFTON Mo.

24. FUNERAL DIRECTOR: J L ZIEGENHEIN & SONS — ADDRESS: 7027 GRAVOIS

25. DATE RECD. BY LOCAL REG.: FEB 16 '59

26. REGISTRAR'S SIGNATURE: Hazel Smith, 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 C. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7037 [illegible]

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.