

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011092

STATE FILE NUMBER
2537

FILED MAR 25 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

S. 300
1-57

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173

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

MEDICAL CERTIFICATION

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 checked="" 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 Incarnate Word Hospital 50 yrs		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 5720 Murdoch Ave
3. NAME OF DECEASED (Type or print) First MIDDLE Last CHARLES HUBERT KINSEY			4. DATE OF DEATH Month Day Year Mar. 10, 1959
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1885
9. AGE (In years at birthday) 73	F 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) shipping clerk		10b. KIND OF BUSINESS OR INDUSTRY wire cloth mfg	11. BIRTHPLACE (City and state or country) Lawrence, Kansas
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Charles Kinsey	13b. MOTHER'S MAIDEN NAME Margaret unknown
14. NAME OF HUSBAND OR WIFE Caroline Meyer		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. 488-07-3045
17. INFORMANT Mrs. Caroline Kinsey, 5720 Murdoch Avenue		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Atherosclerosis.</i> DUE TO (b) <i>Arteriosclerosis Genf.</i> DUE TO (c) <i>Cerebral Thromboses.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Not related to the terminal disease condition given in PART I (a)) <i>Arteriosclerotic Ht. Disease.</i>	INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) 420.1	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>1952</u> to <u>3/10/59</u> and last saw her/him alive on <u>3/10/59</u> . Death occurred at <u>1:45 P.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Charles Kromer, M.D.</i>		22b. ADDRESS <i>1755 S. Grand</i>	22c. DATE SIGNED <i>3/11/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Mar. 13, 1959	23c. NAME OF CEMETERY OR CREMATORY Concordia Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC. 1936 St. Louis Ave		25. DATE RECD. BY LOCAL REG. MAR 12 '59	26. REGISTRAR'S SIGNATURE <i>Walter Smith, M.D.</i>

Dr. Charles Kromer

#16 Hampton Village Plaza

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1/3 - 2780

3:10 Sac-Morp. 45-

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 _____

Licensed Embalmer No. 4520
P. O. Address _____

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.