

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011845  
STATE FILE NUMBER

MAR 18 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 653

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-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Normandy</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Florissant</b> 4000
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Normandy Osteopathic</b>		Length of stay in 1b <b>19 HRS.</b>	d. STREET ADDRESS (If outside, give location) <b>#1 Chesnut Circle</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Kathryn</b> Middle <b>Rae</b> Last <b>Kayser</b>			4. DATE OF DEATH Month <b>3</b> Day <b>11</b> Year <b>59</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-13-59</b>	9. AGE (In years last birthday) Months <b>19</b> Days <b>20</b>	IF UNDER 1 YEAR	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>NORMANDY Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Theodore August Kayser</b>	13b. MOTHER'S MAIDEN NAME <b>Lorena Rae Twellman</b>	14. NAME OF HUSBAND OR WIFE
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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)	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Theodore Kayser</b> Address <b>FLORISSANT</b>
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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) <b>Intracerebral Vary Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5-21-59</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Increased intracranial pressure</b>	
	DUE TO (c) <b>Cerebral hemorrhage from Tentorial Tear</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>7600</b>		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 <b>8:50 A.</b> Month <b>3</b> Day <b>10</b> Year <b>59</b>	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 <b>ST. LOUIS</b>	COUNTY	STATE
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21. I attended the deceased from <b>3/10/59</b> to <b>3/10/59</b> and last saw her alive on <b>3/10/59</b> Death occurred at <b>8:50 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Jay A. Kilpatrick D.O. 2</b>	22b. ADDRESS <b>4601A Pipe Ave, St. Louis</b>	22c. DATE SIGNED <b>3/12/59</b>
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23a. BURIAL CREMATION, RITUAL <b>RETIRED</b>	23b. DATE <b>3-12-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LAUREL HILLS</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Co. MO.</b>
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24. FUNERAL DIRECTOR <b>BUCHHOLZ</b>	ADDRESS <b>5967 W. FLORISSANT</b>	25. DATE RECD. BY LOCAL REG. <b>3-12-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
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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 *Alfred J. Buchholz*  
Licensed Embalmer No. 4551.....  
P. O. Address *A. J. Jones*

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.

*Not Embalmed*