

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015248

STATE FILE NUMBER

2835

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

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 Mo Inside Limits Yes  No

c. CITY OR TOWN ST. LOUIS Inside Limits Yes  No

c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S Hosp. Length of stay in lb 1 DAY

d. STREET ADDRESS (If outside, give location) 4051 OLEATHA Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print) First Middle Last HARRY J. KISTNER

4. DATE OF DEATH Month Day Year MAR. 18 1959

5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED  NEVER MARRIED  WIDOWED  DIVORCED  8. DATE OF BIRTH SEPT 1 1887 9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) METAL POLISHER 10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_ 11. BIRTHPLACE (City and state or country) MISSOURI 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME BERTHOLD KISTNER 13b. MOTHER'S MAIDEN NAME UNKNOWN 14. NAME OF HUSBAND OR WIFE LOUISE KISTNER

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. 492-09-9966 17. INFORMANT Address LOUISE KISTNER 4051 OLEATHA

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 7 days  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Cerebral Vascular Disease unknown  
DUE TO (c) \_\_\_\_\_  
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.) 331X

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. \_\_\_\_\_

20d. INJURY OCCURRED WHILE AT  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 18 Oct 57 to 18 March 59 and last saw him alive on 18 March 59  
Death occurred at 7:55 p. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John F. McClann M.D. 22b. ADDRESS 4401 Hampton 22c. DATE SIGNED 20 March 59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE MAR. 21 1959 23c. NAME OF CEMETERY OR CREMATORY CALVARY CEM. 23d. LOCATION (City, town, or county) (State) ST. LOUIS MO

24. FUNERAL DIRECTOR ADDRESS Thomas Kutis 2906 Morris 25. DATE RECD. BY LOCAL REG. MAR 20 '59 26. REGISTRAR'S SIGNATURE Alan Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

M 9.13

10-100 #121

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 Eleanor Bovine

Licensed Embalmer No. 3403

P. O. Address Jennings

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.