

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015784

STATE FILE NUMBER  
3421

FILED APR 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. 3421

300  
1-57  
291

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>5239 QUINCY</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>5239 QUINCY</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>JENNIE</i> Middle Last <i>STENDEL</i>			4. DATE OF DEATH Month <i>APRIL</i> Day <i>5</i> Year <i>1959</i>		
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5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 25, 1883</i>	9. AGE (In years last birthday) <i>76</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED MATRON</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>BOARD OF EDUCATION</i>	11. BIRTHPLACE (City and state or country) <i>CHICAGO, ILL.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13a. FATHER'S NAME <i>AUGUSTUS KRAUSE</i>	13b. MOTHER'S MAIDEN NAME <i>AMELIA BUSSE</i>	14. NAME OF HUSBAND OR WIFE <i>CHARLES (DECEASED)</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give or unknown) (If yes, give war or dates of service) <i>NO</i>	16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>BERNICE TRINAJSTIC</i> Address <i>5239 QUINCY</i>
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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) <i>Chronic Myocarditis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>422.2</i>		
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 <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.)
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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
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21. I attended the deceased from <i>2-17-59</i> to <i>4-5-59</i> and last saw her alive on <i>4-5-59</i> Death occurred at <i>7:05 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>John A. Smith M.D.</i> (Degree or title)	22b. ADDRESS <i>3739/6 Harris Ave</i>	22c. DATE SIGNED <i>4-6-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>4/8/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CALVARY CEMETERY</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>
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24. FUNERAL DIRECTOR <i>J L ZIEGENHEIN &amp; SONS</i> ADDRESS <i>7027 GRAVOIS</i>	25. DATE RECD. BY LOCAL REG. <i>APR 6 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

ALL DISSEASERS IN PART I MUST BE CAUSALLY RELATED. Doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms with no cause.

**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 *7027 Gravel* .....

**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.**