

**FEDERAL BUREAU OF INVESTIGATION**  
**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS SEP 28 1959**

**59-033976**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **8392**

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|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. Institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>                     | Length of stay in lb<br><b>24 days</b> | c. CITY OR TOWN <b>St. Louis (37)</b>   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Louis Childrens</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>1013 Hopedale</b>     |
| Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                |  |   |   |

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| 3. NAME OF DECEASED<br>(Type or print) <b>Paul Raymond Kistner</b> | First <b>Paul</b> Middle <b>Raymond</b> Last <b>Kistner</b> | 4. DATE OF DEATH<br><b>Sept. 10, 1959</b> | Month <b>Sept.</b> Day <b>10</b> Year <b>1959</b> |
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|                       |                                  |   |                                    |   |   |  |
|-----------------------|----------------------------------|---|------------------------------------|---|---|--|
| 5. SEX<br><b>Male</b> | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-22-58</b> | 9. AGE (last birthday)<br><b>one year</b> | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>7</b> Hours <b>0</b> Min. <b>0</b> | IF UNDER 24 HR<br>Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b> | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis Missouri</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S. A.</b> |
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| 13a. FATHER'S NAME<br><b>William Bernard Kistner</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Margaret <del>SM</del> Schulte</b> | 14. NAME OF HUSBAND OR WIFE<br><b>never married</b> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b> | 16. SOCIAL SECURITY NO.<br><b>None</b> | 17. INFORMANT<br><b>Jane Henrichsen-500 S. Kingshighway</b> | Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>29 days</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>Bilateral Renal Cortical Necrosis</b> |  |
|   | DUE TO (c) <b>603x</b>                              |  |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED?<br>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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|   |                  |
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| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m. | Month, Day, Year |
|---|------------------|

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|--|--|--|----------------------------|--------------------------|
| 20d. INJURY OCCURRED WHILE AT WORK <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<br><b>St. Louis</b> | COUNTY<br><b>St. Louis</b> | STATE<br><b>Missouri</b> |
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| 21. I attended the deceased from <b>8-16-59</b> to <b>9-10-59</b> and last saw him alive on <b>9-10-59</b><br>Death occurred at <b>8:20 am</b> on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE<br><b>Leonard P. Rome</b><br><i>Leonard Peter Rome M.D.</i> | (Degree or title) <b>M.D.</b> | 22b. ADDRESS<br><b>500 S. Kingshighway</b> | 22c. DATE SIGNED<br><b>9-10-59</b> |
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|  |                             |   |  |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b> | 23b. DATE<br><b>9/12/59</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis Mo</b> |
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| 24. FUNERAL DIRECTOR<br><b>Buchholz Mortuary 5967 W. Florissant</b> | ADDRESS | 25. DATE RECD. BY LOCAL REG.<br><b>SEP 11 1959</b> | 26. REGISTRAR'S SIGNATURE<br><b>Paul Smith M.D.</b> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Harvey Kable

Licensed Embalmer No. 4596

P. O. Address St Louis

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.