

# JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034682

FILED VS SEP 16 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2410

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Hgts.</u>		Length of stay in 1b <u>10 yrs.</u>	c. CITY OR TOWN <u>Richmond Heights</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2024 Del Norte Ave.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2024 Del Norte Ave.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First <u>CHRISTINE</u> Middle <u>KASTEN</u> Last <u>KASTEN</u>			<b>4. DATE OF DEATH</b> Month <u>Sept.</u> Day <u>7</u> Year <u>1959</u>		
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<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Aug. 6 1858</u>	<b>9. AGE (last birthday)</b> <u>91</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u> </u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>St. Louis, Mo.</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>
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<b>13a. FATHER'S NAME</b> <u>John Musek</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Frances Polansky</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>Louis Kasten</u>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	<b>17. INFORMANT</b> <u>Emma Kasten</u> Address <u>2024 Del Norte Ave.</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>45 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) <u> </u>		
DUE TO (c) <u> </u>		

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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour <u> </u> a.m. <u> </u> p.m.	Month, Day, Year <u> </u>	
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
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21. I attended the deceased from 10/6/50 to 9:5:59 and last saw her/him alive on 9.6.59  
 Death occurred at 2:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Wm. C. M. M.D.</u>	<b>22b. ADDRESS</b> <u>495-2 Thorne Road</u>	<b>22c. DATE SIGNED</b>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>Sept. 9 1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Resurrection Cem.</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Louis, Mo.</u>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>A.H. Bocklage 6536 Clayton Rd.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-8-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>John B. Murphy M.D.</u>
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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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Elmo R. Padwe

Licensed Embalmer No. 4077  
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.