

# UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 11 1960

'59 044569  
STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. 4249 Registrar's No. 291

ENDED

1. PLACE OF DEATH a. COUNTY <b>Jefferson County</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Hillsboro</b>		Length of stay in 1b <b>years</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cedar Grove Nursing Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3839 Osceola St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>MAMIE</b> Middle <b>A.</b> Last <b>KINSELLA</b>				4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>1959</b>					
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9/12/1886</b>	9. AGE (last birthday) <b>73 yrs.</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>29</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and state or country) <b>Alton, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13a. FATHER'S NAME <b>Paul Maul</b>			13b. MOTHER'S MAIDEN NAME <b>Theresa Meisner</b>			14. NAME OF HUSBAND OR WIFE <b>Martin J. Kinsella</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Thelma Robbe - 3839 Osceola St.</b>				
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>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Huntington's Chorea</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.									
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		COUNTY		STATE	
21. I attended the deceased from <b>Aug. 6, 1956</b> to <b>12/11/59</b> and last saw her alive on <b>12-6-59</b> Death occurred at <b>12:20 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Robert D. Sanders, M.D.</i> (Degree or title)				22b. ADDRESS <b>1502 Cass Ave.</b>			22c. DATE SIGNED <b>12/12/59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12/15/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis County, Missouri</b>				
24. FUNERAL DIRECTOR <b>Gebken Sons</b> ADDRESS <b>2630 Gravois Ave.</b>			25. DATE RECD. BY LOCAL REG. <b>12-12-59</b>		26. REGISTRAR'S SIGNATURE <i>Oliver R. ...</i>				

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS JAN 1 1960

STATEMENT BY LICENSED EMBALMER

JAN 13 1960

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me

for by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Robert E. Laska

Licensed Embalmer No. 4144

P. O. Address St. Louis 18, Mo.

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.