

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS JAN 15 1960

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3457 STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>S t. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural W. llaton</u>		Length of stay in 1b <u>15 minutes</u>	c. CITY OR TOWN <u>St. Louis</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>St. Vincent's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3651 A Philipps Place</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>OCTAVIA</u> Last <u>KIMLING</u>			4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1959</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/14/13</u>	9. AGE (last birthday) <u>46</u>	IF UNDER 1 YEAR Months <u>6</u> Days	IF UNDER 24 HR. Hours <u>12</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Christopher Kimling</u>	13b. MOTHER'S MAIDEN NAME <u>Antoinette Jost</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Miss Ethel Kimling</u> Address <u>3651 A Philipps Place, St. Louis, Mo.</u>
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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) <u>Ruptured Oesophageal Varix with Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) <u>462.1</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? 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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20c. TIME OF INJURY 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 _____ COUNTY _____ STATE _____
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21. I attended the deceased from Dec. 20, 1959 to Dec. 25, 1959 and last saw her/him alive on Dec. 25, 1959  
Death occurred at 11:55 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. B. Lytton</u> (Degree or title) <u>m la</u>	22b. ADDRESS <u>7301 St. Charles Rock Rd.</u>	22c. DATE SIGNED <u>12/25/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec. 28, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
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24. FUNERAL DIRECTOR <u>Kriegshauser</u> ADDRESS <u>4228 S. Kingshighway</u>	25. DATE RECD. BY LOCAL REG. <u>12-26-59</u>	REGISTRAR'S SIGNATURE <u>[Signature]</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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Edwin A. McArthur

Licensed Embalmer No. 3024

P. O. Address \_\_\_\_\_

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.