

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS JAN - 8 1960 317

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3208

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Wellston		Length of stay in 1b 11 days		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Vincent's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2621 Potomac Avenue			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CHARLES Middle WILLIAM Last KURTZEBORN				4. DATE OF DEATH Month Dec. Day 1, Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6-2-80	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months 3 Days	IF UNDER 24 HR Hours 18 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Confectionary		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME William Kurtzeborn			13b. MOTHER'S MAIDEN NAME Dorothy Burbes		14. NAME OF HUSBAND OR WIFE Mrs. Amanda Kurtzeborn		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 487-26-4365		17. INFORMANT Mrs. Amanda Kurtzeborn, wife. 2621 Potomac, St. Louis 18, Missouri		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Uremia						11 days	
DUE TO (b)							
DUE TO (c) Generalized Arteriosclerosis						Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Osteoarthritis -Yrs. Acute Brain Syndrome due to Cerebral Arteriosclerosis						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	
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.) and Uremia - Yrs. Left Inguinal Hernia - Years				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year						
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 11-20-59 to 12-1-59 and last saw him alive on 12-1-59 Death occurred at 7:00 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE S.R. Baetz (Degree or title)				22b. ADDRESS 7301 St. Charles Rock Rd.		22c. DATE SIGNED 12/1/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec 4, 1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri			
24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 ST. LOUIS AVE ADDRESS				25. DATE RECD. BY LOCAL REG. 12-3-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.		

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 _____

Licensed Embalmer No. 4520

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.