

# UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**FILED VS MAY 25 1960**

**=60-021391**

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5156 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Incarnate Word Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2612a Virginia Ave.</u>		
3. NAME OF DECEASED (Type or print) First <u>KATHERINE</u> Middle <u>POSTOL</u> Last			4. DATE OF DEATH Month <u>May</u> Day <u>13th</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-89</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Korce Albania</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Soter Kakalli</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Logor</u>		14. NAME OF HUSBAND OR WIFE <u>Peter Postol</u>		
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 Address <u>Peter Postol 2612a Virginia Ave.</u>			

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) <u>Coronary Occlusion -</u>				<u>1 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive Heart Disease</u>		<u>3 yrs.</u>	
	DUE TO (c) <u>Cerebral Vascular Disease</u>		<u>3-4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.1</u>			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.	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 <u>2-1-1958</u> to <u>5-13-60</u> and last saw her <u>him</u> alive on <u>5-1-60</u> Death occurred at <u>8:15 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Blum Postol M.D.</u> (Degree or title)			22b. ADDRESS <u>3258 Lyette St. St. Louis Mo.</u>		22c. DATE SIGNED <u>5-14-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-17-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Cemetery</u>		23d. LOCATION (City/ town, or county) (State) <u>St. Louis Mo.</u>	
24. FUNERAL DIRECTOR <u>KRIEGSHAUSER 4228 S Kingshighway</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>MAY 16 1960</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u> <u>MCB</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr E. J.  
3258  
Pr 1-0  
until

**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 Heidi A. [Signature]

Licensed Embalmer No. 453

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

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.