URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-024664
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6240

FILED VS JUN 27 1960

ENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 5 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Deaconess
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo b. COUNTY: Franklin
c. CITY OR TOWN: New Haven
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): Hi # 155
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First Henry Middle Christian Last Kehr
4. DATE OF DEATH: Month 6 Day 17 Year 60

5. SEX: M
6. COLOR OR RACE: W
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8/21/1872
9. AGE (last birthday): 87
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm hand
10b. KIND OF BUSINESS OR INDUSTRY: General
11. BIRTHPLACE (City and state or country): Owensville, Mo.
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Unknown Kehr
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Bertha Kottwitz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: L. Chris Kehr, Address: New Haven, Mo. RT 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain Abscess, due undetermined cause
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Purulent Meningitis, due undetermined cause
DUE TO (c) Generalized Arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH: 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 3403
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 6-10-60, to 6-17-60 and last saw him alive on 6-16-60
Death occurred at 10:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: James [illegible] (Degree or title)
22b. ADDRESS: 634 N. Grand Blvd
22c. DATE SIGNED: 6-18-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 6-19-60
23c. NAME OF CEMETERY OR CREMATORY: St. John Cemetery,
23d. LOCATION (City, town, or county) (State): Bem, Mo.

24. FUNERAL DIRECTOR: Schrader Funeral Home, ADDRESS: Ballwin, Mo.
25. DATE RECD. BY LOCAL REG.: JUN 18 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

501

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 Richard M. Pap

Licensed Embalmer No. 458

P. O. Address Baldwin

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