

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-047663

FILED VS. JAN 9 1961

318

Primary Registration District No. 1003

Registrar's No. 12351

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. Louis			Length of stay in 1b		c. CITY OR TOWN LEMAY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. ANTHONY HOSP.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 320 E. RIPA
3. NAME OF DECEASED (Type or print) First Chotilla Middle Kuhage Last S.S.N.D.			4. DATE OF DEATH Month Dec Day 21 Year 1960		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Widowed <input type="checkbox"/>	Never Married <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-18-1888	9. AGE (last birthday) 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ST. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME William Kuhage		13b. MOTHER'S MAIDEN NAME Caroline Schiermann		14. NAME OF HUSBAND OR WIFE —	
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. —		17. INFORMANT Address SISTER MOTHER Theodosia 320 E. RIPA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum					INTERVAL BETWEEN ONSET AND DEATH 18 Mos
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 154x					
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
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 1958 to death and last saw her/him alive on 12/21/60 Death occurred at 9:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE John H. Kelett M.D.		22b. ADDRESS 2623 Telegraph		22c. DATE SIGNED 12-22-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE Dec 24, 1960	23c. NAME OF CEMETERY OR CREMATORY Mother House Cem.		23d. LOCATION (City, town, county) (State) LEMAY Mo.
24. FUNERAL DIRECTOR Shamas Kutis 2906 Gravia		25. DATE RECD. BY LOCAL REG. DEC 24 1960		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2-5 *Oliver & Snyder*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Eleanor Province*

Licensed Embalmer No. 340

P. O. Address 2906 9th

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