

AMENDED

Registered District No. 318

Primary Registration District No. 1003

Registrar's No. 8018

STATE FILE NUMBER -61-030849

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Dade	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Hialeah	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hospital		d. STREET ADDRESS (If outside, give location) 666 East 20th St.	

3. NAME OF DECEASED (Type or print) First Sherrel Middle Jessie Last Kaarup			4. DATE OF DEATH Month August Day 26 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/5/1919	9. AGE (last birthday) 42	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Co.		11. BIRTHPLACE (City and state or country) Plum City, Wisconsin	

13a. FATHER'S NAME Henry Kaarup	13b. MOTHER'S MAIDEN NAME Hilda Newberg	14. NAME OF HUSBAND OR WIFE Betty R. Kaarup
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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) Yes WW II	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Betty R. Kaarup, 10909 S.W. 7th St.
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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) **Pulmonary edema with interstitial nephritis; Pulmonary edema caused by more or less decompensated heart.**

CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.
DUE TO (b) _____
DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
434.f

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No 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.)
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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 _____
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21. I attended the deceased from _____, to _____ and last saw her/him alive on _____.
Death occurred at **7:15 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph M. [Signature]	22b. ADDRESS Room 1300 Clark	22c. DATE SIGNED 8-29-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-28-61	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) Hialeah, Fla.
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24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. AUG 28 1961	26. REGISTRAR'S SIGNATURE Karl Smith, M.D.
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ
BY AFFIDAVIT OF

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 J. W. D. Embler

Licensed Embalmer No. 3655

P. O. Address St Louis 8 Mo

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.