

Registration District No. **316** Primary Registration District No. **1003** Registrar's No. **7828**

FILED AUG 28 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 1 day	c. CITY OR TOWN Bellefontaine Neighbors Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 9768 Colony Drive Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First John Middle N. Last Kasper			4. DATE OF DEATH Month Aug. Day 20 Year 1961			
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-27-1878	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator (retired)		10b. KIND OF BUSINESS OR INDUSTRY St. Louis Public Service Co		11. BIRTHPLACE (City and state or country) Austria	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE deceased		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT Mrs. Wilbur Sullivan, 9768 Colony Dr Address
-----------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute gastroenteritis		INTERVAL BETWEEN ONSET AND DEATH 3d
DUE TO (b) Diabetes mellitus		
DUE TO (c) Diabetes Mellitus		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 260x		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 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 St. Louis	COUNTY Missouri	STATE
--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	--------------------------------------------------	---------------------------	-------

21. I attended the deceased from **Aug. 1951** to **Aug. 20, 1961** and last saw her alive on **Aug. 20, 1961**
Death occurred at **5:47 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. H. Olmsted Degree or title William Olmsted, M.D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 8/21/61
-------------------------------------------------------------------------------------------	----------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE August 23, 1961	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis	(State) Missouri
------------------------------------------------------------	-------------------------------------	---------------------------------------------------------------	-----------------------------------------------------------	----------------------------

24. FUNERAL DIRECTOR Math Hermann & Son, Inc., 2161 E. Fair Ave	25. DATE RECD. BY LOCAL REG. AUG 22 1961	26. REGISTRAR'S SIGNATURE Roal Smith M.D.
-------------------------------------------------------------------------------	----------------------------------------------------	-----------------------------------------------------

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 *Allen W. Hest*

Licensed Embalmer No. 3737

P. O. Address St. Louis 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.