ISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-030862

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7662

FILED AUG 28 1961

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. — Length of stay in 1b over 8 yrs.

c. CITY OR TOWN St. Louis, Mo. — Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 6008a Southwest Ave — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First AGNES Middle V. Last KINGSLAND

4. DATE OF DEATH Month August Day 17th, Year 1961

5. SEX Female

6. COLOR OR RACE White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 9-17-88

9. AGE (last birthday) 72 yrs. — 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) Nil

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (City and state or country) E. St. Louis, Ill.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME James Graney

13b. MOTHER'S MAIDEN NAME Julia ??

14. NAME OF HUSBAND OR WIFE William Kingsland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO.

17. INFORMANT Address Rosemary Kingsland-6008a Southwest

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchopneumonia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Pulmonary embolism with infarct

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

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

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 8-11-52, to 8-17-61 and last saw her/him alive on 8-17-61

Death occurred at 6:30 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Edward G. Dewein M.D.

22b. ADDRESS 5400 Arsenal St.

22c. DATE SIGNED 8-17-61

23a. BURIAL, CREMATION, REMOVAL (specify) Removal

23b. DATE Aug.21,1961

23c. NAME OF CEMETERY OR CREMATORY Resurrection

23d. LOCATION (City, town, or county) (State) St.Louis County., ~~xxx~~ Mo.

24. FUNERAL DIRECTOR Kriegshauser-4228 ADDRESS S.Kingshighway Blvd

25. DATE RECD. BY LOCAL REG. AUG 17 1961

26. REGISTRAR'S SIGNATURE Earl Smith M.D.

MEDICAL CERTIFICATION

DATE AMENDED 3/9/2

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

DOCUMENT

Original - Site - Key

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_____ Signed Ernest W. Spell

Signature of Student Embalmer

Licensed Embalmer No. 4080

P. O. Address_____

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.