

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-31-042589
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10766

AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

FILED NOV 28 1961

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 <u>St. Louis</u>		Length of stay in lb <u>11 days</u>	c. CITY OR TOWN <u>De Soto,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis-Little Rock Hospitals, Inc.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>209 South 5th Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Charles</u>	Middle <u>Louis</u>	Last <u>Kistner</u>	4. DATE OF DEATH	Month <u>Nov.</u>	Day <u>19,</u>	Year <u>1961.</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1888</u>	9. AGE (last birthday) <u>73 yrs</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegrapher</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (City and state or country) <u>Union City, Tenn.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>CHARLES L. KISTNER</u>	13b. MOTHER'S MAIDEN NAME <u>ANNIE SCHUMAKE</u>	14. NAME OF HUSBAND OR WIFE <u>Marie C. KISTNER</u>
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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)	17. INFORMANT Address <u>MRS. ANNA M. ALEXANDER 75 SUNSET DR BERA, OHIO</u>
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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) <u>Myocardial Infarction, Acute</u>	INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>420.1</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Nephrosclerosis</u>	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
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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. 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 COUNTY STATE
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21. I attended the deceased from <u>Nov. 8, 1961</u> to <u>Nov. 19, 1961</u> and last saw him alive on <u>Nov. 19, 1961</u> Death occurred at <u>6:25 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>R. Reiman, M.D.</u>	22b. ADDRESS <u>1755 South Grand Blvd</u>	22c. DATE SIGNED <u>11/20/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>11-22-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. MISSOURI</u>
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24. FUNERAL DIRECTOR ADDRESS <u>R. Lupton & sons Funeral Home 7233 Delmar</u>	25. DATE RECD. BY LOCAL REG. <u>NOV 20 1961</u>	26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>
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DOCUMENT

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 Clarence H. Durr

Licensed Embalmer No. 4015

P. O. Address St. Louis

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.