

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-004031
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1094

FILED FEB 2 1962

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</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>Lutheran Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5731a Dewey</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>Edward</u> Last <u>Kiel</u>			4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>62</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-62</u>	9. AGE (last birthday) <u>3</u> Months <u>15</u> Days <u>53</u> Hours	IF UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>George Edward Kiel</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Margaret Kiel</u>	
14. NAME OF HUSBAND OR WIFE <u>-</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Elizabeth Margaret Kiel</u>		Address <u>5731a Dewey</u>			
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>Meningeal + Spinal Bifida</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>7511</u>					
DUE TO (c)					
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 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 <u>7:05A</u> 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
21. I attended the deceased from <u>1-13-62</u> to <u>1-17-62</u> and last saw her/him alive on <u>1-17-62</u> Death occurred at <u>7:05A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Emelin A. Aiken MD</u>			22b. ADDRESS <u>3701 Grandel Sq.</u>		22c. DATE SIGNED <u>1-17-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>1-31-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
24. FUNERAL DIRECTOR <u>Rowland Mortuary Svc. 4104-06 Manchester</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 25 1962</u>		26. REGISTRAR'S SIGNATURE <u>Lois Smith, M.D.</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

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 _____

Licensed Embalmer No. _____

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.