

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**62-024803**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6686**

STATE FILE NUMBER

**FILED JUL 12 1962**

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>412 West Courtois</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>412 W. Courtois</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Walter L. Kaestner</b>						4. DATE OF DEATH Month Day Year <b>July 5 1962</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4-4-05</b>		9. AGE (last birthday) <b>57</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Continental Grain</b>		11. BIRTHPLACE (City and state or country) <b>Ill.</b>		12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME <b>Gustave Kaestner</b>				13b. MOTHER'S MAIDEN NAME <b>Anna Offerman</b>				14. NAME OF HUSBAND OR WIFE <b>Edna</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>EDna Kaestner 412 West Courtois</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma Cerebellum</b> DUE TO (b) <b>Primary Carcinoma Right Lung</b> DUE TO (c) <b>162.1</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH: <b>2 months</b> <b>4 1/2 months</b>	
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 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 <b>4/11/62</b> to <b>7/5/62</b> and last saw <sup>her</sup> him alive on <b>7/5/62</b> Death occurred at <b>11 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <b>Michael L. Barbusch M.D.</b>						22b. ADDRESS <b>7615 So Broadway</b>			22c. DATE SIGNED <b>7/6/62</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>7-9-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo</b>					
24. FUNERAL DIRECTOR <b>Southern Funeral Home 6322 S. Grand</b>				25. DATE RECD. BY LOCAL REG. <b>JUL 6 1962</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>					

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

VS 300 Rev. 4/59  
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5 **1**  
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13

USE BLACK INK OR TYPEWRITER RIBBON

**90**

Mr. B. Antwick

2-4

**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 James C. Hill

Licensed Embalmer No. 4347

P. O. Address 6322 So Grand

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.