

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-033183  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2096

**FILED JUL 31 1962**

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILL.</b> b. COUNTY <b>ST. CLAIR</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS, MO.</b>		Length of stay in 1b <b>251 DAYS</b>	c. CITY OR TOWN <b>FREEBURG, ILL.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>210 N. MONROE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>KASPER</b> Last		4. DATE OF DEATH Month <b>7</b> Day <b>16</b> Year <b>62</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</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>12-2-77</b>
9. AGE (last birthday) <b>84 YEARS</b>		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) <b>MINNER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COAL MINING</b>	11. BIRTHPLACE (City and state or country) <b>WESTPHALIA, GERMANY</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>FRANK KASPER</b>	
13b. MOTHER'S MAIDEN NAME <b>HEDWIG BINLICH</b>		14. NAME OF HUSBAND OR WIFE <b>TILLIE KASPER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES SPAW</b>		16. SOCIAL SECURITY NO. <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span>	
17. INFORMANT <b>TILLIE KASPER (Wife)</b> Address <b>210 N. Monroe, Freeburg, Ill.</b>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO (b) <b>DECUBITUS ULCER AND CYSTITIS</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS AND DEBILITY</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CHRONIC BRAIN SYNDROME, OLD FRACTURE RIGHT ARM, OLD FRACTURE RIGHT HIP</b>	
INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>		1 YEAR	
20 YEARS		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 <b>VA</b> Month, Day, Year <b>11-7-61</b>		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. Deceased from <b>11-7-61</b> to <b>7-16-62</b> Death occurred at <b>9:25</b> PM on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Deceased or title) <b>SAMUEL E. NICHOLS, M.D. O.D.</b>	
22b. ADDRESS <b>VET. ADM. HOSP; JEFF. BRKS., 25, MO.</b>		22c. DATE SIGNED <b>7-16-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7-17-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Josephs</b>	23d. LOCATION (City, town, or county) (State) <b>Freeburg, Illinois</b>
24. FUNERAL DIRECTOR ADDRESS <b>Geo. Renner &amp; Sons Freeburg, Illinois</b>		25. DATE RECD. BY LOCAL REG. REGISTRAR'S SIGNATURE <b>7-17-62</b> <i>John B. Muffley M.D.</i>	

**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 \_\_\_\_\_ Not embalmed \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Geo Renner \_\_\_\_\_

Licensed Embalmer No. 2314

P. O. Address Belleville, Illinois

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.