

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019505

STATE FILE NUMBER

2 5094

FILED JUN 4 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300  
1-57

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|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>St. Louis</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Missouri Baptist Hospital</b>   |                                  | Length of stay in 1b  | d. STREET ADDRESS (If outside, give location)<br><b>3617 Winnebago</b>  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Carrie</b> Middle <b>Paul</b> Last <b>Paul</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>25</b> Year <b>1959</b>   |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 20, 1883</b>  | 9. AGE (In years at birthday)<br><b>76</b>                                  | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housekeeping</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>   | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Missouri</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13a. FATHER'S NAME<br><b>John Wand</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Henrietta Yurand</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Andrew J. Paul</b>                        |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |   | 17. INFORMANT<br>Address<br><b>Mrs. Mildred Kellogg-4001 Delor St.</b>      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u><i>arteriosclerotic blood disease</i></u>   |                                  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. }<br>DUE TO (b) _____<br>DUE TO (c) _____   |                                  |   |   |   | <b>420.0</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |                                  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.   |                                  |   |   |   |   |
| 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><i>5-9-59</i></u> to <u><i>5-25-59</i></u> and last saw <sup>her</sup> alive on <u><i>5-25-59</i></u><br>Death occurred at <u><i>2:30 A.</i></u> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |   |   |
| 22a. SIGNATURE<br>(Degree or title)<br><i>A. J. Merklein M.D.</i>   |                                  |   | 22b. ADDRESS<br><i>3507 Polona</i>  |   | 22c. DATE SIGNED<br><i>5-26-59</i>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Entombment</b>  | 23b. DATE<br><b>May 27, 1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Hope Mausoleum</b>   |   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Missouri</b> |   |
| 24. FUNERAL DIRECTOR<br><b>WACKER-HELDERLE-3634 Gravois Ave.</b>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>MAY 27 '59</b>   |   | 26. REGISTRAR'S SIGNATURE<br><i>Earl Smith. M.D.</i>                        |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 John J. Krupin  
Licensed Embalmer No. 3497  
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.