WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. 30532

or

Village ..... Primary Registration District No. 1003 Registered No. 8402

or

City St Louis (NO. Sanitarium St. N Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William Kaiser

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: November (Month) 2 (Day), 1878 (Year)

7 AGE: 40 yrs. 10 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Carpenter 712
(b) General nature of industry business, or establishment in which employed (or employer): 703

9 BIRTHPLACE (City or town, State or foreign country): St Paul Ill

PARENTS

10 NAME OF FATHER: Ernst Kaiser

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany

12 MAIDEN NAME OF MOTHER: Julia Boye

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dont Know.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Kaiser

(Address) 7012 Old Manchester Rd

15 Filed SEP 6 1918, 191 Max C. Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 4th (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191..., to ....., 191..., that I last saw h... alive on ....., 191..., and that death occurred, on the date stated above, at 4-15 a. m.

The CAUSE OF DEATH* was as follows:
Fractured Skull
Fall down Elevator Shaft
Whether accidental or intention al

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Not Ascertainable

(Duration) ....yrs....mos....ds.

(Signed) H. W. Futh M. D.

9/5, 1918 (Address) Deputy Coroner

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 9 yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence 7012 Old Manchester Rd

19 PLACE OF BURIAL OR REMOVAL: Walhalla

DATE OF BURIAL: Sept 6, 1918

20 UNDERTAKER: Benderwieden Dunkmeyer

ADDRESS: 1934 St Louis Ave

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St., ... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from

....., 191....., to ....., 191.....

that I last saw h.....alive on ....., 191.....

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
20 UNDERTAKER	**ADDRESS**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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