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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 13782

Township ..... Primary Registration District No. 1003 Registered No. 4133

City St. Louis (No. Mo. Pacific Hospital St. ..... Ward)

2. FULL NAME Ward L. Kaiser

(a) Residence. No. 2205 S. 10th. St., 23 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April, 15th. 1865.

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
62	0	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Indiana

PARENTS

10. NAME OF FATHER John Kaiser

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Indiana

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Indiana

14. INFORMANT Mrs Kaiser
(Address) 2205 S. 10th St.

15. FILED MAY -2 1927 Max C Starkloff REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-30-1927

17. I HEREBY CERTIFY, That I attended deceased from April 27, 1927, 19..., to April 30, 1927 that I last saw him alive on April 30, 1927, and that death occurred, on the date stated above, at 4:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetes Mellitus

57

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chr. Myocarditis
Cardiac Failure

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Regular Laboratory analysis

(Signed) Edwin F. Vitt M.D

5/1, 1927 (Address) Mo-Pac Hos

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Old St. Marcus Cemetery	May-3- 1927

20. UNDERTAKER Wacker-Helderle ADDRESS 2331 S. Bdway

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.