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

Do not use this space.

16903

1. PLACE OF DEATH

County St Louis Mo — Registration District No. 791 — File No.

Township — Primary Registration District No. 1003 — Registered No. 4856

City — (No. Mo Pacific Hosp St. Ward)

2. FULL NAME William Louis Kise

(a) Residence. No. Dupo. Ill St., 19 Ward. Dupo. Ill
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 14 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 8-10-1849

7. AGE: Years 74 — Months 9 — Days 13 — If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Conductor
(b) General nature of industry, business, or establishment in which employed (or employer): Railroad
(c) Name of employer: Mo. Pac. Railroad

9. BIRTHPLACE (CITY OR TOWN): New York
(STATE OR COUNTRY): New York

PARENTS

10. NAME OF FATHER: Adam N. Kise
11. BIRTHPLACE OF FATHER (CITY OR TOWN): New York
(STATE OR COUNTRY): New York
12. MAIDEN NAME OF MOTHER: Julovia Nelson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): New York
(STATE OR COUNTRY): New York

14. INFORMANT: Mrs. Charles J. Bell
(Address) 201 W. 108 St.

15. FILED MAY 24 1927 19 New York City - New York
Max C. Starkloff, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 23 1927

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1927, to May 23, 1927, that I last saw him alive on May 23, 1927, and that death occurred, on the date stated above, at 2:55 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Fracture of Left Hip & Pelvis
Chronic Myocarditis
Due to falling down Stairs
(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (SECONDARY): Senility Accident
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Dupo. Ill.
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory

(Signed) J. A. Lembeck, M.D.
, 19 (Address) 1755 S. Grand Blvd.

*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: Champaign, Ill. — DATE OF BURIAL: 5/25 1927

20. UNDERTAKER: Brichler Und Co. — ADDRESS: E. S. Norris, Ill.

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.

WRITE PLAINLY, WITH ... PERMANENT ...

[illegible]

三 [illegible]

[illegible]

三 [illegible]

[illegible]

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

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

Township..... Primary Registration District No. 1003 Registered No. 4886

City St. Louis (No. ....., ... St. ..... Ward)

2. FULL NAME John Louis Rise

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

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)
M	W	Wd

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	74	9	18	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. FILED JUL 28 1927 Mary B. Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 23 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19....., that I last saw h..... alive on ..... 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

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

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

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

, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-16903