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

Do not use this space.

34697

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 9809

City St Louis (No. 4102a Ashland Ave St. ..... Ward)

2. FULL NAME Martha M. Kaiser

(a) Residence. No. 4102a Ashland St., 10 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)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 25 1881

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	45	10	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Henry Kaiser

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

12. MAIDEN NAME OF MOTHER Catherine Nackmann

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

14. INFORMANT Walter Kaiser
(Address) 3908 Garfield

15. FILED NOV -2 1927 Max C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 1 1927

17. I HEREBY CERTIFY, That I attended deceased from June 26th 1925, to Nov. 1st, 1927 that I last saw her alive on 1st day of November, 1927, and that death occurred, on the date stated above, at 11 30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. Pulmonary. T.B.

31 235 25

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) Tuberculosis of the intestines

(duration) 1 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? —

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Xray - Laboratory

(Signed) Elmer Rickman, M. D

11, 2, 1927 (Address) 5011 Page 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	DATE OF BURIAL
St Peters Cem	Nov. 4 1927
20. UNDERTAKER	**ADDRESS**
A Kron L Alco	2707 N Grand

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.