

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

Do not use this space.

17537

**1. PLACE OF DEATH**

County.....

Registration District No.....

Township.....

Primary Registration District No.....

X City: *St. Louis* (No. *3951*)

*Watah*

File No.....

Registered No. *4449*

St. .... Ward)

**2. FULL NAME**

*Katherine Kaiser*

(a) Residence. No. *3951 Watah*

St., *16* Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *3* yrs. mos. ds.

How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

*Female*

**4. COLOR OR RACE**

*White*

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

*Widow*

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

*Valentine Kaiser*

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

*Oct 14, 1855*

**7. AGE**

YEARS

MONTHS

DAYS

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

*76*

*6*

*21*

**8. OCCUPATION OF DECEASED**

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

*Housewife*

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

*Own Home*

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

*Bellemeille 2*

(STATE OR COUNTRY)

*Illinois*

**10. NAME OF FATHER**

*Mike Roselhardt*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

*Germany 10*

(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

*Marie Adell*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

*Germany*

(STATE OR COUNTRY)

**14. INFORMANT**

(Address)

*Grace Kaiser*

*Bellemeille Del*

**15. FILED**

19 *32*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

*May 5 1932*

**17.**

I HEREBY CERTIFY, That I attended deceased from *April 1932* to *May 5 1932* that I last saw h.e.r. alive on *May 5 1932* and that death occurred, on the date stated above, *11:30 Am.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Arterio Sclerosis*

*93C* (duration) *3* yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

*Chronic hypocarditis*

(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?

*Physical findings*

(Signed) *Pierce W. Powers*, M. D.

, 19 (Address) *2531 So. Jefferson*

\*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**

*Walnut Hill Cemetery - Bellemeille*

*5-8-1932*

**20. UNDERTAKER**

**ADDRESS**

*St. Lawrence*

*Bellemeille Del.*

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.

