

MAY 25 1934

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

Do not use this space.

15326

1. PLACE OF DEATH

County *St. Louis*Registration District No. *1123*Township *Carondelet*Primary Registration District No. *2418 (No. 1)*City *Jefferson-Hannibal* (No. *Veterans Administration Hospital*)

File No. _____

Registered No. *181*

St. _____ Ward)

2. FULL NAME

(a) Residence No. *527 Wilmington St. St. Louis, Mo.* Ward *St. Louis, Mo.*

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *39* yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>M</i>	4. COLOR OR RACE <i>W</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Ethel Kaiser</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>July 19, 1894</i>		
7. AGE	YEARS <i>39</i>	MONTHS <i>9</i>
	DAYS <i>5</i>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Paper Hanger</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>Papering hours</i>	
	10. Date deceased last worked at this occupation (month and year) _____	
11. Total time (years) spent in this occupation _____		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis, Mo.</i>		
FATHER	13. NAME <i>William Kaiser</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis, Mo.</i>	
MOTHER	15. MAIDEN NAME <i>Louisa Riek</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis, Mo.</i>	
17. INFORMANT (ADDRESS) <i>Miss Ethel Kaiser, 527 Wilmington</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Walter Rose Cem.</i> DATE <i>April 27, 1934</i>		
19. UNDERTAKER (ADDRESS) <i>C. Hoffmeister, 1814 Broadway</i>		
20. FILED <i>420</i> , 1934 <i>OB State, Mo.</i> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) <i>Apr. 24, 1934</i>
22. I HEREBY CERTIFY, That I attended deceased from <i>Apr. 18, 1934</i> to <i>Apr. 24, 1934</i>
I last saw him alive on <i>Apr. 24, 1934</i> Death is said to have occurred on the date stated above, at <i>7:30 p.m.</i>
The principal cause of death and related causes of importance were as follows: <i>Tuberculosis, pulmonary chronic for a number of years.</i>
Other contributory causes of importance: <i>27!</i>
Name of operation _____ Date of _____
What test confirmed diagnosis? <i>Urinal - sediment</i> Was there an autopsy? <i>No</i>
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____ Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place. _____
Manner of injury _____ Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____
(Signed) <i>H. S. Veterans Administration</i> M. D. (Address) <i>Jefferson Hannibal Mo</i>

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.

