

June!

State File No. **33999**
Registrar's No. **8537**

NOV 13 1939

Registration District No. **791**

Primary Registration District No. _____

1. PLACE OF DEATH: **1003**
(a) County _____
(b) City or town **St. Louis, Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4525 Maffitt Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days _____

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **1**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4525 Maffitt Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME **SOPHIA M. KAYSER 260**
3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **October** day **4**
year **1939** hour **8** minute **8** A.M.

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widow**
6. (b) Name of husband or wife **George W. Kayser** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **September 25 1876**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May 25**, 19**39**, to **Oct 4**, 19**39**; that I last saw him alive on **Oct 3**, 19**39**; and that death occurred on the date and hour stated above.

8. AGE: Years **63** Months **0** Days **9** If less than one day _____ hr. _____ min.

Immediate cause of death **Cerebral Hemorrhage**
Ademat.
Duration **10 days**

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

Due to **Arteriosclerosis**
Chronic Myocarditis
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

10. Usual occupation **at home**

Major findings: **none**
Of operations _____
Of autopsy **no**

11. Industry or business **at home**
12. Name **Fred G. Block 9**
13. Birthplace **not known not known**
(City, town, or county) (State or foreign country)
14. Maiden name **Charlotte Boedeker**
15. Birthplace **not known Germany**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature **Mrs. Charlotte Kayser**
(b) Address **4525 Maffitt Ave**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

17. (a) **burial** (b) Date thereof **19 6 39**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Matthew's**

23. Signature **Haras A. Meyer** (M. D. or other) _____
Address **4903 Delmar** Date signed **10-5-39**

18. (a) Signature of funeral director **A. Kwon L. D. Co**
(b) Address **2707 North Grand Bl**
19. (a) **OCT 5 1939** (b) **J. Block**
(Date received local registrar) (Signature of registrar)

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. 2631
working under my personal supervision.

Signed Paul F. Kullenberg

Licensed Embalmer No. 2631

P. O. Address 2707 A Grand

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.